SEXUALITY, SEXUAL AND REPRODUCTIVE HEALTH: AN EXPLORATION OF THE KNOWLEDGE, ATTITUDES AND BELIEFS OF GREEK-CYPRIOT ADOLESCENTS

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ABSTRACT

The study examines the knowledge, attitudes and beliefs of Greek-Cypriot adolescents regarding sexuality, sexual and reproductive health in Cyprus and is based on the concepts of culture, gender and sexuality under the general scope of health promotion and health education. The study reviews international and local literature on the theory and practice of these ideas and their influence on health, focusing on sexuality. Since culture and society are thought to influence health and sexuality, an extensive discussion is presented on the history of Cyprus and its development in contemporary years.

This is a Pan-Cyprian study of 697 third grade students (13-15 years old) in public general secondary (high) education schools (gymnasium) in Cyprus. A close-ended questionnaire was designed including 51 questions. Three axes were taken in consideration: Knowledge; resources and needs; attitudes and beliefs. With the application of statistical analyses such as factor and cluster analysis, several results were drawn. Among other things the findings reveal that socio-cultural determinants such as religion/church, do have enormous impact on Greek-Cypriot adolescents' attitudes and beliefs. Although young people do have some knowledge about sexuality, limited resources and services exist to support and reinforce that. In the Cypriot society of the 21st century some conservatism and taboo still exist. Gender differences are apparent. Greek-Cypriot society at some point seems to have different expectations, roles and even a 'code of ethics' among males and females.

Researching sexuality issues is a challenge since up until recently sexuality was very much a taboo area. Contemporary Cypriot society is becoming more sensitive and open about it even though a degree of conservatism still exists. However, there is limited scientific evidence on sexuality matters. This study

aims to provide some evidence. When a shift in attitudes takes place is firstly noticed among adolescents.

Based on the literature review and the results of this study a theoretical explanatory model was developed. At the end, the study highlights its conclusions and several recommendations are made for future investigation and progress in the fields of health and education.

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CHAPTER 1

INTRODUCTION

"No Knowledge is more crucial than knowledge about health. Without it, no other life goal can be successfully achieved"
(Ernest L. Boyer in Marx et al., 1998:43)

1.1 Background of the study

Health promotion has rapidly acquired a significant role within the field of health and health care. It is an important and vital force in the public health movement (Bunton and MacDonald, 1992). Health promotion involves the population as a whole within the context of their everyday life (WHO, 1994). It is a mediating strategy between individuals and environment, synthesizing personal choice and responsibility in health to create a healthier future (WHO, 1986). Yeo (1993), added that health promotion is a reform movement that advocates the shifting of priorities and resources to align with a broader way of thinking about health thus it can be seen as a powerful social intervention for protection and maintenance of health.

A vast number of health promotion campaigns, prevention projects or programmes have been focusing on different health related matters, such as smoking, alcohol, heart disease. After the HIV/AIDS epidemic people began to think more seriously about sexual matters. Almost two decades after the need for more information, re-shaping attitudes and beliefs regarding sexuality still challenges many societies. Sexual preparedness while it is also so crucial to saving lives (e.g. from HIV/AIDS, unsafe abortions) remains most of the times a controversial issue (Gomez, 1995). Even though the picture of sexual and reproductive health in the world appears to be gloomy, there is much ground for optimism about health development due to the growing respect for human rights particularly for women (Nakajima, 1992).

Globally, most people become sexually active during adolescence and thus, many adolescents are bearing children (Safe Motherhood, 1998; FPA, 1998). Additionally, the use of emergency contraception has increased in recent years (FPA, 1998). Arguably, it seems that there is lack of knowledge or misinformation related to the use or misuse of emergency contraception. There is also an increase of unsafe and casual sex. According to the Alan Guttmacher Institute (AGI, 1998a), seven in ten young girls in America, who had sex before the age of 14 and six in ten of those who had sex before the age of 15, reported having had sex against their will. Adolescent girls may lack self-confidence and decision-making skills to refuse unwanted sex. Girls who experience sexual abuse or rape can suffer from serious physical and psychological consequences (Safe Motherhood, 1998).

Each year, worldwide, girls aged 15-19 undergo at least five million induced abortions, thus being exposed to the possibility of having an unsafe one. Usually the reasons for an abortion are the fear of life change that one can have with a baby, the feeling of immaturity and financial problems (AGI, 1998a). In addition, it is estimated that worldwide, one in twenty adolescents every year contract a Sexually Transmitted Infection (STI) including HIV/AIDS (Safe Motherhood, 1998).

Adolescent development emerges from an interaction between the socialization processes of childhood, physical maturation, the socio-cultural pressures associated with adolescence itself and the active self-agency of the individual (Hendry et al., 1995). Adolescents have to go through and adjust to a biological, psychological, emotional and social development. Although adolescence is considered to be a healthy stage of the lifespan, it may be the genesis of behavioural patterns, which are carried into adulthood with possible health risks (Hendry et al., 1995). Sexuality is one of the factors that is very much affected during this stage. Even though sexuality is

experienced by everybody, it is an area that is least discussed and understood. Many adolescents get mixed messages (from parents, peers, media etc.) and they might pass through their adolescent years not understanding the monumental changes that they are experiencing (Alvarez, 1995).

Many factors such as family, education, culture, religion, attitudes, beliefs and values (these will be explored in the following chapters) influence adolescent sexuality. Many sexually related practices are deeply embedded in various cultures and may be considered as physically harmless or even beneficial to a young person, such as male circumcision for Jews; others can be harmful, such as the practice of female genital mutilation that many women are experiencing. In Catholicism and Orthodoxy contraception is considered a sin; in some countries polygamy is the norm whilst in others is a crime. It can be argued that changing any cultural practice might probably be unacceptable or even unethical for any society. However, reshaping, transforming, re-evaluating some aspects of cultural behaviour that might be harmful to people's health can prevent illness, promote well-being and improve quality of life. Cultural and socio-political structures have enormous power in understanding and expressing sexuality or health in general.

Sexuality education is considered, especially for adolescents, to be one of the major aspects of promoting health through adopting healthier life styles. There are arguments, though, that education for sexuality has limited or no effect in delaying the initiation of sexual intercourse (DiCenso et al., 2002). However, all research studies acknowledge that there is improvement of knowledge and almost all mention that the focus should be on socio-cultural determinants (DiCenso et al., 2002; Pastore and Diaz, 1998; Villaruel, 1998).

The International Planned Parenthood Federation (IPPF)/Youth Manifesto (2001a:3) summarizes the importance of sexuality for young people setting three goals:

- Young people must have information and education on sexuality and best possible sexual and reproductive health services;
- Young people must be able to be active citizens in their society and
- Young people must be able to have pleasure and confidence in relationships and all aspects of sexuality, by having more choices than those imposed by society's gender roles, choices that they can decide and feel happy about.

Cypriot society has European and Middle Eastern cultural characteristics. According to Kalava (in Mylona et al., 1982), the patriarchic nature of Cypriot culture - meaning that the male is the breadwinner, the leader of the family, the main figure in socio-political events - has restricted major changes or transformations to cultural norms, traditions and values which relate to sexuality, reproductive health and gender roles. However, in recent years socio-cultural changes seem to be taking place. This is mainly due to an increase in inward migration, which inevitably requires social and political adjustments to be made including changes in attitudes to gender roles.

In Cyprus, every year, there are on average 24 new HIV/AIDS reported cases. During the year 2001 twenty-three (7 Cypriots and 16 Foreign Nationals) new HIV/AIDS cases were reported. According to the World Health Organization (WHO) the number of HIV infected people currently living in Cyprus is estimated at 300-500. This corresponds to a rate of 0.06%-0.1% in the population between 15 to 49 years of age. In relation to world estimates these numbers are the 0.1 of crude world rate, 0.25 of rate of the Eastern Europe and 0.5 of the rate of Middle East (Ministry of Health, 2001). During the year 2001, 88 cases of genital warts have been reported of which

56% were young people 17-30 years old. In addition, 27 cases of syphilis have been reported of which 48% included young people 20-30 years old; and from 141 cases of genital herpes 11% included young people 15-30 years old (Ministry of Health, 2002). The numbers might seem to be small compared to other countries, but for such a small country (estimated population of Cyprus in 2001 was 762,887) and keeping in mind the socio-cultural influences this is gradually becoming a serious problem. Some of the factors that bring about such changes may be: the loosening of family ties currently being witnessed, reaction to previous strict sexual code of behaviour, improved financial affluence, a more contemporary interpretation of Christian values and beliefs, the influx of foreign artistes and new immigrants, and the increase in tourism. Further, Cypriots that are traveling abroad (for business, study or vacation) may engage in casual sex or intravenous drug use. Before 1993, only 14% of all known HIV cases were infected in Cyprus; by 1999 50% of the cases were infected in the island (Ministry of Health, 2001).

Sexual assault, sexual harassment, rape and other types of abuse have been increasing in recent years. According to the Association for the Prevention and Handling of Domestic Violence (2000) during the year 2000 (January-November 2000), 590 victims (492 women, 38 adolescents, 47, children, 13 men) of physical and/or sexual violence asked for help in terms of psychological support, counseling and/or shelter.

The Greek-Orthodox church has enormous power on the Cypriot society's norms and values. Sexual issues are considered as taboos by the church. Sex is something expressed within marriage. Premarital sex and contraception are considered as sins. Premarital sex was the main reason that in 1999 the Cyprus church abandoned the 'engagement' ceremony. Church representatives felt responsible of encouraging the tradition of young people living together after their engagement. The influence of the Cypriot

church is such that even people who do not consider themselves to be very religious are deeply affected by the moral codes advocated by the church. Having an illegitimate child is severely frowned upon by the Cypriot society that marginalizes both the women and the children involved. The woman is considered to bring dishonour to her family and is therefore also excluded and marginalized by them too. In order to preserve the family honour (Loizos and Papataxiarchis, 1991) the family will do its utmost to conceal the pregnancy and will put enormous psychological pressure on the woman to abort the foetus. However, the church also holds the view that abortion is a sin even in the case of rape. The Cypriot law permits abortion under certain circumstances, usually medical reasons (see chapter 5). Cypriot families and young people who find themselves in such dilemmas may often choose abortion as the social stigma of having an illegitimate child will last longer and have more profound consequences than the sin of abortion– for which they can be forgiven by the priest upon confession.

Twenty-eight abortions were performed in public hospitals for the year of 2000 (Cyprus Statistical Service, 2000a). There is no available data for the private hospitals or clinics. A small number of cases of young women who either tried to self-induce abortion or give birth whilst alone at home have recently been reported (Filelefttheros, 2001a).

In contemporary Cyprus, more people are becoming aware and sensitive to gender and sexuality matters. Women are very slowly gaining their equality within society, since most of them are working outside the home and are more independent, not only financially but also psychosocially. In 1980 sixty-five (65) children were born outside wedlock; in 1990 seventy-seven (77) and in 2000 one hundred and ninety-seven (197) (Lambraki, 2002). Notwithstanding this level and type of change, many Cypriots still hold very traditional and conservative attitudes towards these issues. For example, it is acceptable or even exhortative for boys to have premarital relationships,

while the urge for the girls is to preserve their virginity. Furthermore, since Cyprus is a small country, personal reputation is important. Most of the times people pay attention to and pass judgment on the female sexual behaviour whilst male sexual behaviours are taken for granted and pass unnoticed. This can create an enormous psychological pressure for many young women that sometimes may be harmful to their health.

The scope in promoting adolescent sexual health is to prevent or minimize any unwanted conditions, and to identify choices that young people may have when in a serious dilemma. Sexuality education has been included since 1992 as a unit of the secondary school health education programme. It can be argued that for several reasons, such as the sensitivity of the topic, the high level of privacy about it within Cypriot society and the limited resources available for its implementation has resulted in this not been effective. However, there is no research evidence to support this. In recent years there has been an on-going debate regarding the benefits of sexuality education in schools and how this can best be implemented and accepted within the Cypriot culture. A pilot programme that was planned to start in December 2001 was postponed to commence in the academic year 2002-2003. It is anticipated that its evaluation will be of great interest to both the general public and to many health and education professionals. The Cyprus Family Planning Association (2003) believes that in parallel to an effective school programme the support services for young people must be improved.

The rationale for this study arose from all these concerns, as the researcher views sexuality as a crucial part of health. It is the researcher's assumption that many professionals in the fields of health and education usually ignore this aspect of health. Further, it is assumed that cultural beliefs and attitudes influence the sexual health of Cypriot adolescents as they influence their

knowledge and awareness in issues regarding sexuality. It is also believed that there are gender differences in understanding sexuality among Cypriot adolescents.

Politics might be of equal importance in promoting sexual health. Decriminalization of homosexuality in 1998 was probably the most 'liberal revolution' of the Cypriot parliamentarians. However, most of the politicians do not usually publicly express their opinion about sexuality issues. Politicians though can often be successful agents of change through their conveyance of health messages as well as in influencing the implementation of health promotion programmes.

This study will try to offer thought and challenge to Cypriot people, especially young people, in understanding their own sexuality and sexual and reproductive health needs within the context of culture.

1.2 Concepts and Definitions

It is essential to define and discuss how some ideas/ concepts are used and understood in this study. All of the following terms have been given a variety of definitions. Some will be explored in more detail throughout this study.

Health is a fundamental human right, a precondition of well-being and the quality of life (WHO, 1998). It is a resource for everyday life, not an objective of living (Ewles and Simnett, 1992). Health is the foundation for achieving a person's realistic potential; it is about empowering people, enabling them to become all they are capable of becoming (Seedhouse, 1986). The meaning of health for each individual is influenced by one's own beliefs, values, gender and culture. For example, slimness in Western societies is a culturally defined standard for female beauty and health, while among the Enga people of the New Guinea Highlands a 'fat body' was rewarded as the most important physical asset of a woman (Helman, 1994). In either case one's health may be influenced. In extreme cases some young women can have anorexia nervosa due to obsessive slimness, or cardiovascular problems as a complication of obesity.

The ability to adapt to constant changing demands, expectations and stimuli is a characteristic of a healthy person. Some people view health as the absence of illness or disease. However, others have a more holistic view of health based on one's psychosocial, cultural and physical well-being. For example, a single parent consults a physician because he/she feels depressed. The physician may be tempted to prescribe medication that induces a state of well-being; the alternative may be to refer him/her to a peer support group where life-skills and autonomy can be promoted (Tannahill et al.,1990).

In the first International Conference on Health Promotion, in Ottawa in 1986, a Charter for action to achieve Health For All by the year 2000 and beyond was presented. The Charter (1986:1) stated that *health promotion* is the "...process of enabling people to increase control over, and to improve their health". Health promotion is a multi-factorial process operating on individuals, communities through education, prevention and protection measures (Tannahill, 1985). Some health professionals believe that they have to apply persuasive strategies; others aim in assisting people to learn and apply healthier lifestyles. One can argue, that if people cannot understand the primary purpose of a specific prevention act (e.g. for unwanted pregnancies) and the personal and social consequences, then it will be very difficult to use techniques or methods to alter behaviour. Applying a persuasive strategy alone can probably be successful in short term.

In promoting health, emphasis is given to the concept of positive health. This means a 'true well-being', where the individual and society are of significant value. It entails a balance of physical, mental and social ingredients (Tannahill et al., 1990). All three components are of equal importance and any alteration on anyone will affect health. The health promotion knowledge base is multi-disciplinary and this alone is a strong asset in effectively preventing unwanted or ill-conditions. Nevertheless, organization, collaboration and cooperation will enhance the effort in the promotion of health. The World Health Organization (WHO, 1984) identified certain principles of health promotion that are comprehensive, clear and useful in understanding and practicing health promotion.

Thus, *health promotion:*

- involves the population as a whole in the context of everyday life
- is directed towards action on the determinants or causes of health
- combines diverse but complementary approaches which include education, legislation and community development

- aims at effective and concrete public participation, which will lead to the development of problem-defining and decision making life skills
- is an activity in health and social fields

In 1998 within the context of Health21 the WHO, enriched and explored in more depth the above principles. As to ensure scientific, economic, social and political sustainability four main strategies for action were chosen:

- multi-sectoral strategies to tackle the determinants of health
- integrated family and community-oriented primary health care
- a participatory health development process that involves partners for health at home, school, work and at local community and country levels and that promotes joint decision-making, implementation and accountability
- health-outcome driven programmes and investments for health development and clinical care

Tones (1991) referred to health promotion as an umbrella term, which includes any activity and sector that is designed to improve health; and health education is one of the most important activities that influences health.

Health education is "...communication activity aimed at enhancing positive health and preventing or diminishing ill health in individuals and groups, through influencing the beliefs, attitudes and behaviour of those with power and of the community at large" (Smith, as cited by Tannahill et al., 1990:28). Effective health education can produce changes in ways of thinking; it may influence or clarify values; it may shape a belief or an attitude; it may even affect changes in behaviour or lifestyle (Tones and Tilford, 1994). Education is not a panacea but is a useful tool in promoting health. Nevertheless, philosophers of education highlighted the autonomy of the individual as the central goal of education. Health education itself is a valuable tool and thus,

educational methods that promote autonomy and empowerment must be of a priority. Furthermore, the primary aim is to educate people in such a way as to enable them to develop the ability, skills and confidence to make healthy choices. However, teaching and learning is still largely about acceptance of the rules of others (Bunton and MacDonald, 1992). Educational institutions such as schools should try to promote autonomy not only at personal level but at societal level too. Effective health education involves adopting active and participatory methods and spiral integrated curricula, starting where people are, cognitively, emotionally and developmentally (Bunton and MacDonald, 1992).

Health education is concerned not simply with raising individual competence and knowledge about health, but with raising awareness about social, cultural, political and environmental factors that influence health. Education is for the individual to develop the theoretical and practical background as to understand and respect different ways of thinking and practicing within the diversity of people and societies (Green and Tones, in Wilson and McAndrew, 2000).

Health promotion and health education are seen as having a symbiotic relationship. The aim through these processes is to improve health. Therefore, empowerment is an ultimate goal at personal and communal level. "The self-empowered person is more likely to possess a high internal locus of control" (Tones, 1985:79), meaning that one is likely to have developed a firm conviction that is not controlled by fate or someone else (Apostolidou, 1999). Significant association has been reported between internal locus of control and different health measures (e.g. reduction of alcohol consumption). If one respects and values one self, it is more likely that he/she will look after him/herself (Tones, 1991). The development of healthy attitudes and behaviour can be encouraged by education. However, motivation, ability and responsibility rest with the individual primarily, as well as the health educator

(Jamieson et al., in Wilson and McAndrew, 2000). Emphasis must be given in doing things *with* people and not *to* people.

Despite one's own idiosyncrasy, many times one's cultural background can reinforce or restrain possibilities of empowerment, meaning that within each culture different opportunities and flexibilities exist for the individual to reach empowerment and a healthy state of life. Socio-cultural factors cannot only influence empowerment but health and health promotion too.

Culture is a unique part of one's own personal identity that has been defined by Tylor (1871/1958:1) as the "... complex whole which includes knowledge, beliefs, arts, morals, law, customs and any other capabilities and habits acquired by man as a member of society". According to Leininger (1995:60) "...culture refers to the learned, shared, and transmitted knowledge of values, beliefs, norms and lifeways of a particular group in their thinking, decisions and actions in patterned ways". Generally, culture can be seen as that which constitutes humanity or distinguishes a specific society from another (Gausset, 2001). It is the way that life is shared within an environment by a group of people. As societies are becoming more and more multi-cultural, it is necessary to understand the beliefs, attitudes and behaviour of other people as to achieve a harmonious relationship between cultures, societies and individuals.

The meaning of illness is influenced by a person's cultural background. The aetiology, symptoms, possible outcomes and treatment, often are distinctive from one culture to another and may reflect peculiar beliefs, customs or tensions that are prominent in that culture (Gallagher, 2000). Regardless of these and far from being static, culture is dynamic and capable of adapting to new conditions (Gausset, 2001). Undoubtedly, culture is a major component in influencing health and consequently in developing and expressing

sexuality. It is also acceptable that there are differences as well as similarities between cultures. People express their sexuality differently in Afghanistan than in Paris or Japan.

Sexuality is "...interwoven with every aspect of human existence. In its broadest sense, it is a desire for contact, warmth, tenderness or love. Humans express their sexuality during daily life" (Poorman, 1988:1). The biological aspect of sexuality is one of its components that cannot be ignored. The continuation of human species is very important. Sex also has its own meaning within the notion of human sexuality. Overemphasis on biological aspect can underestimate the significance of socio-cultural aspect of sexuality.

Sexual matters are of great importance but in many societies they are viewed as 'secrets'. In many societies the everyday language that people use is full of sexual innuendo, slang and joking. This signifies that people think of and may be problematized about sexual matters, but also demonstrates that these cannot be discussed openly without embarrassment (Evans, in Morrissey, 1998). Slang words or joking, may be used intentionally or unintentionally to mask the feeling of being uncomfortable in discussing such issues. Many people today, throughout the world, are deprived of their sexual and reproductive rights (see chapter 4). Being able to freely express sexuality is one of the most joyful and enriching aspects of human experience (Pratt, in Wilson and Mc Andrew, 2000). All these do have an impact on one's health, because sexuality is an integral part of a human being.

Gender also has a strong impact on human sexuality. Gender goes beyond the chromosomal or biological sex of being a man or a woman and tries to understand individuals as male or female figures within their socio-cultural and physical environments. One of the central elements in gender systems is

the taboo against the sameness of male and female (Hess and Feree, 1987). Much literature reveals the uniqueness and commonalities of expressing male or female sexuality. Nevertheless, sexuality and gender are separate organizing features of social relations but intersect by mutually reinforcing, naturalizing and constituting each other (Schippers, 2000).

Sexuality education is challenging wherever or at whatever age might be applied. It is aiming to teach adolescents (preferably even earlier than that), about their physical and psychosexual development. It also aims to develop skills, shape attitudes, beliefs and values. These will cultivate critical thinking, increase self-respect and self-awareness and may change behaviour (Sinanidou, 1997). Sexuality education is not presented here as a 'magic recipe' that will solve or eliminated all unwanted conditions, but it is a useful tool for reducing or preventing those and, thus, promoting health. Sexuality education concerns everyone-parents, educators, policy makers, mass media etc. Strong partnerships will enhance effectiveness of such programmes. Furthermore, a multi-disciplinary team can provide a more open, diverse and comprehensive approach to sexuality issues than a single person (whoever that can be) (Creatsas, 1998). It is important that young people, especially adolescents, not only learn about their sexual health, but become involved in such programmes thus contributing to the programmes' development and control (Thomas, 1996).

Adolescents are "...a diverse group of people and popular stereotypes underestimate their variety and exaggerate their liabilities, as stereotypes tend to do" (Durkin, as cited by Bergman and Scott, 2001:194). The uniqueness of each one adolescent along with the similarities as a group in sexuality matters are some of the reasons that this research is focused on adolescents. Needless to say that sexual maturation, sexual identity and sexual intercourse are some of the issues that can create concern, ambiguity,

experimentation, challenge and fear to most of the adolescents. This is the point where adolescents need to be aware of the right and healthy choices. Therefore, attitudes, beliefs, behaviour, information and knowledge are probably better to be delivered, shaped or formed much before reaching this stage of life. Adolescent development, as previously mentioned, emerges from an interaction among the socialization processes of childhood, physical maturation and the socio-cultural environment. Therefore, within the contexts of health promotion and everyday culture, adolescents and sexuality are of significant concern.

1.3 Aims and Objectives

Aim

The aim of this study is to examine Greek Cypriot adolescents' knowledge, attitudes and beliefs about sexuality, and sexual and reproductive health and to explore the influence of the dynamic interplay of transnational and local socio-cultural norms and values.

Objectives

- To identify the cultural factors which influence sexuality, and sexual and reproductive health attitudes and beliefs of Greek Cypriot adolescents;
- To describe the knowledge, attitudes and beliefs of Greek Cypriot adolescents about sexuality, and sexual and reproductive health;
- To assess Greek Cypriot adolescents' awareness of the existing resources related to sexuality issues; and
- To develop explanatory frameworks based on the impact of local and transnational socio-political and cultural norms and values on sexuality and sexual and reproductive health

1.4 Overview of the Thesis

Following the introduction (*Chapter 1*), chapters 2-5 are composing the literature review. The concept of culture is discussed in the *second Chapter* exploring its complexity as well as its influence on everyday life. Health and well-being are inseparable aspects of daily living and thus culture is very much related with. In this chapter emphasis is given to the relation of culture in the form of attitudes, values, beliefs and sexuality links with health. Discussing the blending of culture and health, their influence on adolescents' beliefs and behaviour worldwide could not have been ignored. Moreover, as gender is part of culture *Chapter 3* analyses the relation amongst them. While many researchers have focused on biological differences, others explored gender as an important determinant of health, including the socio-cultural aspect of it (Wamala and Agren, 2002). This chapter discusses gender and its components such as gender roles, gender stereotypes within a cultural context and this is essential in promoting health. Adding to the discussion, the concept of sexuality becomes more challenging. Sexuality is produced within gender relations. Cultural and social constructions of gender, influences how one understands and expresses his/her own sexuality. Within these parameters adolescent sexuality is also discussed in this chapter in relation to gender and culture, providing evidence from different cultures and societies and their influence on sexual health.

Chapter 4 refers to sexuality in more detail and presents several theoretical approaches on this topic. At the same time a distinction is made on what is sexuality and sexual and reproductive health. As sexuality embraces many aspects of human existence such as political and economic, politics could not be neglected during the process of reviewing the literature and some examples are mentioned such as the reinstatement of 'Mexico City Policy' by George Bush. Furthermore, Chapter 4 extensively discusses the impact of education for sexuality in promoting health. As the study was undertaken in

Cyprus, it was necessary to explore the meaning of sexuality within Cypriot society and culture and how they may affect Greek-Cypriot people's well-being. These issues are discussed in *Chapter 5*, providing a historical and contemporary perspective of Cyprus. Several factors are explored as strong influencing components of the Greek-Cypriot culture such as church/religion, education, mass media. *Chapter 6* describes in detail the methodology used for the implementation of this study including sampling, the instrument, the methods of data collection and analysis. The ethical implications are also discussed. In *Chapter 7* the research findings are presented. It includes simple and advance statistical analyses and tests that were applied for the purpose of this study. The chapter is divided into different sections according to the theme that is being investigated based on the questionnaire given, for example, knowledge, attitudes and beliefs. The interpretation of the results and a critical discussion of them are found in *Chapter 8*. This chapter is also divided in similar sections, according to the responses of the participants in each theme such as knowledge, resources/needs. In the same chapter the development of an explanatory framework/model is presented as to understand sexuality within Greek-Cypriot culture. The overall idea is to prevent unwanted conditions and promote not only sexual health but a holistic view of well-being. The framework is based on the findings and literature review as they are understood and interpreted within the parameters of culture, gender and sexuality. The final chapter of the thesis, *Chapter 9*, presents the conclusions and recommendations of the study, highlighting at the same time its contribution. In addition, a framework of partnerships among existing or new resources on sexual and reproductive health is introduced aiming at a better collaboration and coordination.

CHAPTER 2

CULTURE

Introduction

There are hundreds of definitions on culture. Culture includes ideas, beliefs, language, institutions and structures of power and a range of various practices, encompassing artistic forms, architecture, work and leisure activities, and popular and elite media products (Grossberg et al., 1992). As culture in this study is considered as the principal idea of understanding sexuality, this chapter explores the concept of culture. Within these parameters the relation of culture, health, and sexuality of adolescents are extensively discussed.

2.1 Culture

Culture is a complex concept that needs to be clarified in order to understand health related knowledge, health related practices and health promotion. Researchers from different disciplines and professions, such as anthropologists, sociologists, psychologists and -in recent years- health professionals such as nurses, offer numerous definitions and analyses related to culture. However, many authors also highlight common features of culture.

More than a century ago, Tylor (1871/1958:1) defined culture as a "...complex whole, which includes knowledge, beliefs, arts, morals, law, customs and any other capabilities and habits acquired by man as a member of society". These 'capabilities and habits' seem to include everything (e.g. language, professions or disciplines). Williams (1981:13) stated that culture "...includes not only the traditional arts and forms of intellectual production but also all the 'signifying practices' -from language through the arts and philosophy to journalism, fashion and advertising- which now constitute this complex and necessarily extended field".

According to Leininger (1995:60) "...culture refers to the learned, shared, and transmitted knowledge of values, beliefs, norms and lifeways of a particular group in their thinking, decisions and actions in patterned ways". Leininger goes even further to give a more comprehensive and clear definition. It is a holistic view of the individual as he/she inherits a set of guidelines and at the same time transmits these to the next generation. This process is fascinating because is endless. The 'set of guidelines' might change throughout the years, but the transmission will never stop.

Helman (1994:2), viewed culture in similar way as "...a set of guidelines which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation- by the use of symbols, language, art and ritual". Helman and Leininger emphasize the significance of culture in relation to health and health education.

The above definitions imply that each human society has its own meanings and purposes. Culture has two aspects: firstly, the known meanings and directions, which its members are trained to and secondly, the new observations and meanings, which are offered and tested (Williams, in Gray and McGuigan, 1997). These are the ordinary processes of human societies and human minds. Williams goes on to say that culture can be traditional and creative with ordinary common meanings and the finest individual meanings. Therefore, the ordinary is found in the contemporary, conventional, the popular and the everyday culture. It is in everyday objects, everyday talk and in all the daily aspects of each person's life (Silverstone, 1994). Willis (1990) not only agrees that culture is ordinary but goes one step further to say that culture is the extraordinary in the ordinary. The extraordinary creativity that people use in their social practices, personal styles and choices, is a crucial

variable for the individual identity formation. It helps one to find his/her own identity and place, in a sense, by remaking the world for one's self. Most young people's lives are not involved with arts and yet are full of expressions, signs and symbols through which individuals seek creatively to establish their presence, identity and meaning. People are constantly expressing something about their actual or potential cultural significance (Willis, 1990). Symbolic creativity is "...more fully the practice, the making or the essence, what all practices have in common, it is what drives them" (Willis, in Gray and McGuigan, 1997:208). Symbolic creativity helps to produce specific forms of human identity and capacity (Willis, 1990).

Society also has a vital role in forming or transforming oneself or identity. Some argue that the individual is a product of the society and the culture in which one lives. From the moment humans are born and throughout their lives, they have social relations and are part of a network of other people (Burkitt, 1991). These social interactions and meanings include a cultural aspect that influences one's identity and a way of life.

Fiske (in Grossberg et al., 1992), argued that it is difficult to study empirically or theoretically the everyday culture of people. He added that this may be the reason that culture of everyday life is concrete, contextualized and lived. Bourdieu's (1984 and 1977) theory of 'habitus' is a way of thinking through and analyzing the material practices of everyday culture and the difficulty in studying them. Bourdieu argued that 'habitus' produces dispositions and that individuals make choices according to their habitus. Some argue that 'habitus' embodies the attitudes which one inherits; it does not constitute a stimulus which conditions how one should behave (Robbins, 2000). The concept of 'habitus' contains the meanings of habitat, the processes of habitation and habit, especially habits of thought. People live within a social environment (their habitat). This is a product of its position in the social space and of the practices of the social beings that inhabit it (Grossberg et al., 1992).

Bourdieu's theory may be considered to be useful because it relates cultural and textual differences to social and economic ones. There are a variety of ways in experiencing social conditions and their different ways of knowing, thinking and producing culture. The vitality of a culture could be a source of social change (Fiske, in Grossberg et al., 1992). Individuals in different situations have different capacities to generate positions, but all individuals possess some capacity for positional change (Robbins, 2000). Arguably, one may challenge the social environment and provide different 'habitus' and dispositions.

The study of culture is concerned with everything that is meaningful in connection to power relations. "...Power is everywhere; not because it embraces everything, but because it comes from everywhere" (Foucault, 1980:93). Post-Structuralists, like Foucault, are more interested in the way that language is used with other social and cultural practices (Storey, 1993). The use of language and/or messages, are always articulated by social and cultural practices. These power relations need to be considered in understanding culture. Power should not be viewed negatively; it is productive and produces knowledge (Storey, 1993). However, sometimes power may not be used for promoting good. As culture is a multidimensional issue, involving politics and policy making, economy and the wider society negative power relations may occur (Gray and McGuigan, 1997). For example, one could argue that political differences and conflict between countries or even within countries may be due to differing cultural beliefs and values such as in Ireland, Afghanistan and Cyprus. Foucault argues that power could exist without knowledge, while knowledge would have nothing to integrate without differential power relations. He also argues that there is a connection between knowledge and individuality. He goes further to say that true knowledge is defined by the individual, but what is permitted to count is defined by discourse. Discourse associates the organization of social

relations as power relations (Storey, 1993). Therefore, acquiring knowledge about individual's health issues for health promotion is a step towards gaining power. However, since culture may influence behaviour, it can have an impact on one's understanding of a given knowledge of health. Furthermore, culture may acquire power as it contributes to the identity formation, the cultural production and consumption. Nevertheless, one is encouraged to search and find sources of power, as to enable him/her to do or become what he/she can actually do or become.

Even though there seems to be a difference between Bourdieu's and Foucault's analyses of culture, at the same time their ideas seem to have some resemblance too in how they view the cultural environment.

Humans are more similar to one another than they are different (Brown, 1991). Cultural differences still do exist. Triandis (1994:3) supports that "...we are not aware of our culture unless we come in contact with another one". Even after exposure to other cultures, people are most likely to use the framework of one's own cultural background in interpreting the events. For example, among the Karaki of New Guinea a man is 'abnormal' if he has not engaged in homosexual behaviour prior to marriage. In other countries this may be characterized as exactly the opposite (Triandis, 1994).

Cultures are never homogeneous nor static. Thus, generalizations should be avoided; many times there is a difference between the professed 'social norms' of a cultural group and actual cultural practice. Cultures are influenced by other cultures around them. For example, there is a difference for Muslims living in United States of America and the Muslims living in Saudi Arabia. Muslims living in the United States have multicultural interactions. Their daily stimuli differ from Muslims living in Saudi Arabia. They include non-Muslim or non-Islamic beliefs, attitudes or behaviour. Therefore, the culture of Muslim's living in America is arguably less static than the culture of those living in

Saudi Arabia due to the numerous exogenous factors which impact on their cultural beliefs and practices.

Helman (1994) argues that there is a continuous adaptation process to culture and a constant change. Despite this, certain beliefs, values and practices do persist (Kottak and Kozaitis, 1999). Bauman (1999), highlighted that cultures become inter-dependant and all are diversified. Some cultures have similarities in their beliefs and/or common practices. Interacting with other cultures may or may not bring about changes in one's value system (Watson, 1992). Culture is absorbed unconsciously. Many times people do or say things that they have not really thought about, but have acquired or learned from their everyday life within their culture. 'Social spacing', for example, is not actually taught. It is a gradual process of observation. How far or close North Americans, Russians, Greeks or Italians stand from each other, is learned as a part of their culture (Kottak and Kozaitis, 1999). Thus, hugging, kissing or talking are strongly influenced by culture.

Whether inherited or acquired culture is an inseparable part of human beings. During enculturation people internalize meanings and symbols of their culture. It is the process by which someone learns his/her culture (Kottak and Kozaitis, 1999). Environment, as product of group of individuals, with its own culture -norms, beliefs, values and habits- challenges the individual as to reject, change, adjust or adopt his/her culture. Helman (1994) argued that the culture into which one is born or in which one lives, is not the only influence on his/her life. Gender, personality, education and social class are some of the factors that may influence one's life and health as well as their cultural background.

Cultural habits persist only as long as they satisfy people's needs. Gratification strengthens habits and beliefs (Kozier et al., 1991). It could be argued that this is not applicable to everyone or everything. Cultural habits

and/or norms may not only be unsatisfying to certain people or circumstances but even harmful in some cultures such as female genital mutilation, early age arranged marriages and the burning of widows. Thus, forms of cultural expression reveal power relations within groups; for some people the same practice may offer satisfaction whilst for others may be a negative experience.

Gray and McGuigan (1997) argue that people should learn to think globally while acting locally, developing concepts and forms of writing which will create the links between knowledgeable communities and larger systems. Nowadays, there is a considerable interest in exploring the cultural implications of groupings such as the European Union (E.U.). The dynamics of globalization are more complex than people may think or imagine (Gray and McGuigan, 1997). Belonging to a politically or economically powerful group, one shares this power. For example, each country wishing to be part of the E.U. must meet certain criteria and make specific constitutional changes, which inevitably have socio-cultural ramifications, while at the same time keeping its own cultural identity. It seems that this is not an easy task. Certain people or communities want to preserve the uniqueness of their culture without allowing any transformation or change. Arguably, with globalization cultures may no longer be seen as separate from one another. Either way, some elements of culture do diffuse from one culture to another (Triandis, 1994).

Theories related to biology, ecology and social structure are more likely to be universal (Triandis, 1994). At the same time, each phenomenon has also its cultural specific aspect. Thus, one may respect, accept or apply certain aspects of universality, but retain unique parts of one's own culture. Globalization, acculturation and multiculturalism offer the opportunity to exchange cultural practices, values, attitudes and beliefs, broaden people's horizons, acknowledge and understand people from other communities and cultures and share what is considered to be useful and beneficial for each

culture and community. It is possible that positive interactions among individuals or groups of people may occur. For example, occupational groups, genders, social movements and corporations can become the bases of specific subcultures (Triandis, 1994). Adolescents, health professionals, educators, males and females may consider being the bases of specific subculture. Subculture "...is closely related to culture and refers to a group that deviates in certain areas from the dominant culture in values, beliefs, norms, moral codes and ways of living with some distinctive features of its own" (Leininger, 1995:60). Unfortunately, cultural interaction is not always positive or beneficial. People may adopt attitudes, behaviours, practices or even values harmful to them or 'culturally inappropriate' within their community. For example, whilst in some countries cohabitation, multiple sex partners or same sex families are acceptable, these are not so in Cyprus where even premarital sex may inhibit a person from receiving the Holy Communion.

The tendency to judge the behaviour and beliefs of people from a different culture based on one's own cultural standards, probably only creates difficulties among people. Ethnocentrism is better to be avoided; and instead one should learn to appreciate the best that humans have produced, no matter where it was developed (Triandis, 1994). Cultural relativism may be more beneficial, if it is used appropriately and not in the extreme. This implies that it is not possible to judge one culture as objectively superior to another (Taylor, 1997). Human diversity must be respected as well as certain international standards of justice and morality (Kottak and Kozaitis, 1999), as long as they do not intervene with the authenticity of the cultural identity of a particular community. Ethnocentrism is not the only barrier for intercultural or transcultural communications and relations, stereotypes are equally inhibiting.

Stereotyping means "...assuming that all members of a culture or ethnic group are alike" (Kozier et al., 1991:745). Once a stereotype is in place, it

influences one's processing of information and behaviour to that person or group. When there is a contact with a person or group that one has a stereotype this is activated immediately (Trandis, 1994). For example, one may assume that all Italians express their pain volubly (Kozier et al., 1991). The more contact there is with a person, group or culture, the more acceptant one is likely to be. Nevertheless, each individual is unique. Stereotypes will be discussed in more detail in chapter 3.

The beliefs and concepts one has regarding race and ethnicity are another two important parameters that can influence one's understanding of other people's cultural practices or beliefs. Race "...is characterized by physical appearance, determined by ancestry and perceived as a permanent genetic state" (Fernando, 1991 as cited by Papadopoulos et al., 1998:2). Since all people are equal, no race can be considered as superior or inferior to another. History reveals that race inequalities existed within or among cultures. Even in contemporary years, in some countries, certain races are not treated as equals. Ethnicity "...is the basis for defining groups of people who feel themselves to be separated in multiracial and multicultural societies. It implies a sense of belonging" (Fernando, 1991 as cited by Papadopoulos et al., 1998:2) and belonging is an important human need. Ethnicity is perceived as partially changeable, while race is perceived as permanent (genetic/biological), (Papadopoulos et al., 1998). Whatever approach one may adopt for ethnicity, all of them agree that it is related to the "...classification of people and group relationship" (Eriksen, in Guiberrnau and Rex, 1998:34). Misconceptions or stereotypes that exist for a particular race or ethnic group affect the attitudes and behaviour towards others. Since many societies are becoming multicultural and more diverse, such obstacles must be minimized or eliminated.

Nowadays, with the traveling, migration, resettlement, mass media and technology universality cultural blending, challenging and problematizing occurs.

Health is very much related to the individual's experience, identity and culture. In comprehending health, it is important to understand one's own culture (Helman, 1990). Culture guides each person's thinking, doing and being. Therefore, exploring health within each person's culture could reinforce the individual's potential, knowledge and power and thus promote health. Attitudes, values, beliefs and behaviour are shared parts of culture and therefore, are directly linked with health. One may argue that these may be viewed as a form of guidelines (among other factors) that lead the individual to form an opinion, make decisions and take actions in certain matters.

As one of the aims of this study is to describe the attitudes and beliefs of adolescents regarding sexuality and the influence of socio-cultural factors on these, it is necessary to discuss, comprehend and relate attitudes, values and beliefs to health and sexuality.

2.2 Attitudes, Values, Beliefs and Sexual Health Behaviour

The relationship between attitudes, beliefs and behaviour has been the object of study of social scientists for many years.

The origin of the idea of attitude goes back in the fourth century B.C. in Aristotle. His treatise on "Rhetoric" described the principles that generated persuasion- the ways people change others' attitudes (Brewer and Crano, 1994).

There is a number of definitions of what an attitude is. **Attitude** is "...a relatively stable tendency to respond consistently to particular people, objects or situations" (Roediger et al., 1984:587). Since attitudes are 'relatively stable', they may change. Moreover, one's own behaviour does not always

provide an indication of his/her attitude. An attitude must be towards something (Tannahill et al., 1990).

More specifically attitudes are based on three components:

a) A cognitive component concerned an individual's belief about the object or attitude. This belief may be biased, untrue or inaccurate.

b) An affective component concerned with feelings, likes and dislikes and emotions (Tannahill et al., 1990). For example, a young adolescent boy may believe that alcohol can damage his sexual health. Nevertheless, because of the enjoyment and the feeling he experiences, when drinking, he does continue to do so.

c) A conative component, which is the behavioural component of an attitude (Tannahill et al., 1990); it is the disposition or intention towards action (Fishbein and Ajzen, 1975).

Identification of attitudes may be carried out directly (by questioning) or indirectly (by behavioural observation) (Tannahill et al., 1990). However, the link between attitudes and behaviour is not automatic. As the La Piere study showed attitudes may not influence behaviour (Brehm and Kassin, 1996). Ajzen (1991), argued that attitudes influence behaviour through a process of deliberate decision making (theory of planned behaviour). Attitudes towards a specific behaviour or the expression of self combine subjective norms and perceived control to influence a person's intentions. These intentions guide but do not completely determine behaviour or how one expresses his/herself within a specific context such as sexuality. This theory has been used successfully to predict behaviour, such as using condoms, smoking, attending church, making moral and ethical decisions (Brehm and Kassin, 1996). Ethnic identity and acculturation influence attitudes (Gurung and Mehta, 2001) and therefore sexual behaviour and sexuality in general. American Indians with a strong cultural background and identity are more able to adapt in Western culture and not be threatened by it (Gloria and Kurpius, 2001).

Related to attitudes and influencing behaviour are values. **Values** are also expressed in behaviour based on beliefs about objects, persons or situations and are accompanied by feelings of approval or disapproval. For example, some people may judge that conduct likely to risk the spread of AIDS is wrong. Therefore, if one has a certain belief, he/she chooses one mode of behaviour than other and disapproves others who act differently. Values are preferences that express attitudes and affect attitudes (Tannahill et al., 1990). Schwartz (1992:2), defined values as "...concepts or beliefs that pertain to desirable end states or behaviours, that transcend specific situations, that guide selection or evaluation of behaviour and events and are ordered by relative importance". Therefore, values become an important issue in improving health, since health promotion is concerned with changing attitudes.

Rabinowitz and Valian (2000), reported that women's desire for older mates with high earning capacity and men's desire for younger mates (with good domestic skills) are based on the value individuals place on domestic work. These situations are moderately to strongly correlated with indices of gender equality in society. Social-role theory states that the division of labor by sex within a society drives mate preferences. In modern or equal societies women do not need rich and older men. It seems that there are also other social or cultural factors that a woman, in a modern society, may choose to do that so. Unmarried women (over 30 years old) may purposefully marry a much older man as to avoid gossip (for being an 'old-maid' or for different male friends) within a conservative society.

Values are shown by consistent patterns of behaviour. Once an individual is aware of one's values, they become an internal control of behaviour (Kozier et al. 1991).

Beliefs are formed from experience. They are judgments about truth or probability of propositions, which are statements of reality (Tannahill et al., 1990). They are based more on faith than on fact. Family traditions are beliefs

passed from one generation to another (Kozier et al., 1991). Thus people's beliefs may or may not be true. A strongly held, dogmatic belief and resistance to change may be harmful for one's health. In a study at Okanagan College in Canada, students refused the possibility to believe that AIDS may strike people like themselves. Most of them, whether monogamous or promiscuous believed their partners could not possibly be infected. This belief was not so realistic because they had reported high number of partners in their past (Netting, 1992). Moore et al. (1996), in their study showed that young teenage girls beliefs about contraception, before and after they became sexually active, influenced their intentions and eventual use of the pill. One's own religion, culture, taboos, fear of sexual activity and the personal meaning of sexuality may form these beliefs.

It has been also found that sexual self-beliefs are an important factor related to the virginity status, level of sexual risk-taking, numbers of sexual partners and casual sex (Rosenthal et al., 1999). Sexual self-beliefs "...examine individual's sexual perceptions of themselves with respect to physiology (arousal), the externalization of desire (exploration), interpersonal priorities (commitment) and reaction to sexual situations (anxiety)" (Rosenthal et al., 1999:322). Culture influences self-belief and belief system guides everyday behaviour. It is a usual phenomenon that people will hold a belief that is mainly convenient to them. Most of the smokers believe that smoking is harmful, but also believe that by continuing smoking would make no difference to their future experience of illness (Tannahill et al., 1990).

It is obvious that beliefs involve values, but not always though. Generally, attitudes offer justifications for feelings, give emotional meaning to beliefs and provide purpose for actions. Thus, attitudes, values and beliefs are influencing parameters in one's expressing his/her sexuality, preserving and promoting his/her own sexual health.

2.3 Culture and Health

The different cultures around the world have their beliefs about health, illness and healing. In everyday life health is so important and a great deal of human effort has gone into the creation and establishment of beliefs and practices concerning health (Weller and Baer, 2001). There is considerable evidence that culture is related to health status of individuals and communities. Some common factors that may be affected by culture are alcohol consumption, diet and sexuality (Triandis, 1994). In understanding health and illness in relation to culture, it is important to avoid 'victim-blaming'; meaning seeing culture as the only reason for people's poor health.

Health behaviour may be conscious or unconscious by an individual and is directly related to the individual's culture and meanings of health. Since cultural background has a significant influence on many (if not all) aspects of life, culture has important implications for health and health care (Helman, 1994). Thus, understanding culture is essential for explaining 'unhealthy' or risky behaviours such as smoking, unsafe sex and so on. However, what is important for one individual may not be important to another. There are differences among people's health beliefs and behaviours (Helman, 1994). Therefore, individuals or subcultures may need a different approach to health promotion, prevention and protection.

Worldwide, people have a variety of beliefs and practices used for promoting health, preventing and curing illness. Some of these have been proven to be helpful over the years, some are questionable or even harmful. In Latin America many people believed in the 'Hot-Cold Theory of Disease'. 'Hot and Cold' is used as a symbolic power contained in different substances, such as food, herbs etc. They believe that heat and cold should be in balance as to maintain health. For example, menstruation is considered to be a 'hot' state, thus is treated by the ingestion of 'cold' food, medicines or procedures. Some Latin American women may avoid some fruits and vegetables that are liable

to clot menstrual blood and this may cause deficiency in certain vitamins (Helman, 1994). The Chinese believe that health is a balance between negative and positive forces (yin and yang) (Kozier et al., 1991). The Cypriot monk Filaretos (1924), has written extensively about the healing procedures used in Cyprus such as the use of alcohol or dog milk in the ear to relieve pain and the drinking of parsley with vinegar to cure haemoptysis. Some of these remedies are still used today, mainly by older Cypriot people. Jews from ancient years practiced male circumcision for religious and hygienic reasons. In China acupuncture is a mode of treatment, in the Unites States the chiropractic approach is used for certain conditions such as headache and chronic pain (Helman, 1994), while other cultures may find these as inappropriate approaches to health and illness.

Although a variety of definitions for health have been described throughout the years (see chapter 1, section 1.2), culture is a parameter that should not be ignored. As discussed above, culturally constructed health and health beliefs result in a wide range of unique patterns in health seeking and maintenance behaviours in different societies; therefore, illness and health are directly related to culture (Torsch and Ma, 2000).

Although the importance of the cultural dimension of health has been recognized by a number of 19th and 20th century anthropologists and gained recognition amongst health professionals in the 20th century, the 21st century is posing even greater challenges to health policy makers and health providers. According to Papadopoulos (in Daly et al., 2002a), even though multicultural societies are becoming the norm this does not mean that all individuals within them enjoy equal and fair treatment, and have the human rights respected and protected. Probably one of the main challenges for health professionals is to become culturally competent in order to provide effective health care, which is culturally appropriate.

Within the health care system people from minority ethnic groups encounter in addition to cultural barriers, problems with racism, prejudice and discrimination. Therefore, may have poorer physical and mental health. Some barriers of the low use of mental health services are that minority groups are more likely to be mandated to mental health treatment, to receive severe and stigmatizing diagnoses, to be inappropriately diagnosed and to have less positive mental health outcomes. Moreover, cultural and linguistic mismatches may contribute to discrepant termination rates across groups. Compare with Whites, African Americans reported higher levels of negative attitudes, fear of hospitalization related to mental health services. Adding to these, sexual orientation is rarely addressed in African American reports in relation to the use of mental health services (Matthews and Hughes, 2001).

Culture is a complex and global variable that influences behaviour in a myriad ways. Greek-Cypriots living in Britain reported that one of the three most important reasons that cause them high level of stress is family. Greek-Cypriot parents expect to care for their children, who will stay with them until they are married. This is unlike the accepted or even expected practice within the indigenous population (Papadopoulos, in Papadopoulos et al., 1998). Advantages or disadvantages of such attitude or practice will not be discussed here, but it is obvious that this can have an impact on one's health. Nevertheless, this is a culturally 'appropriate' behaviour.

Drinking or even drunkness are good-naturedly tolerated and somehow accepted by Japanese people. Intoxication allows them to express freely, without any fear of repercussion (Gannon, 2001). On the other hand, most -if not all- of the countries have restrictions about alcohol use. The Japanese behaviour could be harmful not only for themselves at long-term, but short-term to others (e.g. accidents, violence) as well.

Individuals in each community share and are subject to cultural values that have been adapted to their specific community, using multiple strategies to adopt their health status, limitations and capabilities to their settings (Torsch and Ma, 2000). Caplan (1993), mentioned that a quite large proportion of Mathare, Kenyan women (20% of 63 women) reported that sex is needed to keep them healthy. In Kikuyu society there is no word for celibacy or orgasm. Abstention from sex is physical and psychological impossibility. However, this attitude and behaviour exposes people to Sexually Transmitted Infections (STI's) and HIV/AIDS, particularly when sexual intercourse takes place without the use of condoms.

Traditions, cultural practices and other factors influence a community's absorption of health knowledge. People will not accept modern knowledge unless those offering it show an understanding of local knowledge and sensitivity to their cultural norms. Therefore, an integration of modern and traditional practices may improve public health, by increasing the acceptability of modern health related knowledge and harnessing the curative power of traditional knowledge (WHO, 2000). These are not easy to apply especially in certain deep-rooted sensitive beliefs, cultural norms and practices, such as female genital mutilation.

Cultural idiosyncrasy of a country is reflected in its system of health and the promotion of health practices. When someone is hospitalized in Cyprus, frequent and large family visitations are expected, while for White Americans individual visitations normally occur. Furthermore, cultural systems have the capacity to shape health perceptions and behaviours (Torsch and Ma, 2000). Kotchich et al. (2001), mentioned that Black female adolescents are more likely to report having multiple partners than White or Latina adolescents, among teenagers who were either currently pregnant or had already children (in U.S.A.).

Mass media play an important role on culture. It projects people's desires, dreams or needs. Media enables the development of diffuse and ambiguous lifestyles and images; youth, beauty, fitness, luxury (Featherstone, in Featherstone et al., 1993). Messages and more specific health messages need to be clear and directed at achieving better health status (Lupton, 1994). Advertisements use symbols and metaphors to link a meaningless product with desirable cultural values. For example, a soft drink advertisement, which uses young attractive people pass on the value of youth and sexual attractiveness. When such advertisements are used on a global scale, as in this case, they have the power to influence the development of universal cultural values. Research indicates that ethnicity plays an important role in media viewing choices. Young African Americans spend more time watching television than White youths. The fundamental notion is that the greater the exposure in the media, the greater the possibility that young people will adopt the values, beliefs and behaviours that are portrayed (Gruber and Grube, 2000). Repetitive advertisements, for example, such as luxurious cars showing the easiness of sexual attractiveness or easiness to have sex, is challenging for youth. These advertisements 'sell' in addition to the products they promote attitudes, beliefs and behaviours. These may have an adverse effect on one's health. However, mass media such as television also delivers a variety of programmes in people's homes. Many young people may become familiar with abortion, divorce, prostitution and sex through television. Creatsas (1993) suggested that media can have a positive influence on teenage attitudes, when they watch informative programmes on sexual or any other health issue.

As human societies persist with their complexity modes and meanings of social interaction exist together. Modes of social interaction include concepts (such as norm, role), which call one's attention to the pattern of behaviour that societal members follow and the society's expectations that others should follow these patterns (Luhman, 1989). For example, playing the role of

a married woman it is 'normally' expected to bare children. Meanings of social interaction include cultural elements (e.g. values, knowledge), that direct one's attention to the thoughts that societal members have about their behaviours and the reasons one develops for following them (Luhman, 1989). Therefore, health-related attitudes, values and beliefs are products of social interaction. The avoidance of undertaking the analysis of cultural process may serve as a limitation in some health promotion/ education approaches (e.g. behavioural change model). Health promotion takes place within a culture. There is also an increased recognition of significant role of the social and cultural variables in explaining the adoption of new behaviours and lifestyles (Bunton et al., 1991). The identification and knowledge of one's own socio-cultural practices and beliefs are probably the initial steps in understanding the role of health promotion within everyday culture.

Each person brings to the health care environment a heritage of customs, beliefs, traditions, religious rituals and habits that gives a portrait of one's own identity, individuality and personality (Flarey, 1999). Thus, health promoters, health professionals and educators should consider culture as a vital variable for an effective and efficient promotion of health.

2.4 Culture, Sexuality and Adolescents

For many generations, all over the world, sexuality was largely ignored or it was assumed that all sexuality was covered by the facts of marriage and procreation. Homosexuality was mainly addressed in negative or pejorative terms. Differences between genders, and sexual relations were not so much discussed, until recent years, when the HIV/AIDS epidemic intruded in thousands of people's lives-mainly young people. Moreover, culture was considered as an irrelevant issue in relation to adolescent sexual health or even more generally in relation to sexuality. There is no doubt that taboos on sex in society and science are to blame for this history (Herdt, 1999).

According to Triandis (1994:1) "...culture is to society what memory is to individuals", underlying the power that culture has on the individual. Memory often influences present feelings, attitudes, beliefs and thus behaviour. This is crucial during adolescence, where there is ambivalence and experimentation about one's own personal identity. Since the concept of culture suggests that members of social groups share common norms, values and ways of interpreting the world around them, therefore how one sees oneself (his/her identity), can only be understood in relation to culture (Taylor, 1997). Consequently, there is an important relationship between cultural identity and adolescents. Identity provides a link between one's inner sense of self and the place one occupies in social and cultural world (e.g. within family, workplace) (Taylor, 1997). Interaction with other people, socialization and learning of one's own culture are vital to the formation of identity. Adolescent's sense of cultural identity includes "...race, ethnicity, language and nationality. It is also defined by the groups of people with whom the adolescent shares values, norms, traditions and customs" (WHO, 1999:135).

Adolescence is "...a period of turbulent transformation from childhood to adulthood, where youth undergoes many physical, emotional, cognitive and

psychological changes. It is also a period of experimentation that can involve risk taking" (American Medical Association, 1995:3). However, in order to have a holistic view of adolescence, one must look at it from different perspectives: biological, cognitive and psychosociocultural. Physical changes are more or less obvious and are taken in consideration during puberty, while psychosocial transformations often need more meticulous attention. The emotions of oneself, the development of self-esteem, identity, sexuality and interpersonal relationships are some of the things that adolescents experience. Society, culture and subculture are significant parameters that influence adolescents regarding these challenges or transformations. Although cultural boundaries separating youth from children or from adults are not so clear, adolescents are considered to be the young people between the ages 13-19. The experience of being young is universal, but it takes many different forms- cultural, political, personal. People negotiate cultural processes that are formed by them to some extent. When these cultural processes are formed by young people, this is youth culture. This is a diversified, complex phenomenon (Talai and Wulff, 1995) but a common one. Adolescents many times create their own language, code of communication or dressing. As they try to pass through the childhood-adolescence process, they analyse and challenge their home culture, creating their own, autonomous and unique youth culture.

There are several factors that influence adolescents' attitudes, beliefs and behaviour such as family, culture, religion, race, peer groups. These may have an impact on adolescents' sexual and reproductive health. Adolescents develop subcultures with their own language, styles and value system that are not necessarily approved by adults, but by peers. Adolescents whose peers reported to engage in risk-taking behaviours were more likely to engage in risky sexual behaviours (Scaffa, in Henderson et al., 1998). In contrast to that, there is a view that adolescents reflect adult values beliefs and practices (Rice, 1996) and this is understandable. Adults- parents, family,

adult friends or popular persons- are the role models of young people. They can be either positive or negative role models.

Different studies showed that parents might play a significant role in sexual development, particularly knowledge and attitudes. However, it is difficult to determine which parent factors have the greatest impact and what are the implications of the timing of communication (Somers and Paulson, 2000). In contrast to these, other studies indicated no relation between parental communication on sexuality and adolescent sexuality (Miller and Fox, 1987). In Somers and Paulson study (2000), that was done among adolescents from two suburban high schools in the Midwest (U.S.A.), it was found that younger age and less parental communication were related to less sexual behaviour and knowledge. In the same study it was also found that being younger and female and receiving less maternal communication was related to less sexual behaviour and more conservative attitudes. One may conclude from these findings that parent-adolescent communication about sexuality issues has an impact on adolescent sexuality, since greater parental communication leads to greater sexual knowledge. However, gender differences exist among these relations.

Even though literature suggests that adolescents report wanting to receive information from their parents and parents wanting to provide information, some studies found that only a small percentage have had such interactions with their parents (White and De Blassie, 1992). Furthermore, the stereotype that adolescents (as a group) are in a mass rebellion against their parents and parental values is simply not true (Rice, 1996). Undoubtedly, adolescence is a time that children try to consolidate their independence (Rice, 1996), but this is an essential process of becoming a mature adult.

Parents within their own culture, taboos, knowledge and ignorance may often avoid not discuss sexuality issues with their children. Even when they do, they may usually talk about the biological aspects of a subject such as the

physiology of menstruation. In a telephone survey, among Latino adults living in the United States, more than half of the respondents reported that their mothers had never spoken to them about sex and 58% of men and 82% of women said that their fathers had never spoken to them about sex during youth (Gomez, 1995). This finding is of concern because according to Villarruel (1998), parental communication is a major mean for the transmission of cultural values and probably the most effective one. There is no doubt, that parents are the first to 'implant' values, attitudes and beliefs in their children. Cultural environment, including school and peers, will cultivate and influence this base in a positive or negative form. The influence of the cultural environment naturally extends to matters of sexual health.

Adolescents may feel part of their parents' culture, but they may also feel part of a youth or several youth cultures (WHO, 1999).

It is interesting that American adolescents, whose parents reported to have higher educational attainment, were less likely to ever be engaged in sexual intercourse (Santelli et al., 2000). This may suggest that more educated parents communicate with and transmit more or better quality of knowledge to adolescents. Knowledge can influence values, behaviour or cultural practices within a family. Ignorance of damaging health behaviour, with the lack of insight, stands in the way of providing adolescents with greater opportunity for a healthy behaviour (WHO, 1995).

In spite of this, parental communication about sexuality does not appear to be a sufficient factor to explain adolescents' individual differences in sexual development (Somers and Paulson, 2000). Dilorio et al. (2000) suggested that family based programmes will provide the opportunity for the parents to be able to feel confident that information and knowledge provided to their children are correct and appropriate. Health messages, especially those related to sexuality, are challenging and not easy to be followed by adolescents, but once adopted, they can provide a better quality of life.

For adolescents sexual activity is more than a biological need. It is a key marker to adulthood. In addition, for many young people sexual choice symbolizes the freedom to experiment. Sexual decisions are filtered through at least three culturally determined factors: the meaning of sexuality, the process of male-female negotiations and youths' perceptions of danger (Netting, 1992). In all societies there is a meaning of particular sexual behaviour. What messages each society passes through its people and how people interpret them are mainly products of culture. This implies that parameters that have a strong relation with culture, such as religion, play a significant role in adolescents' sexual behaviour. For example, if monogamy its of high value, within a culture, then an important percentage of its people will probably adopt this. In addition to this, there is evidence that cultural stereotypes and religious taboos influence the age and the reason for initiation of sexual activity (HEA, 1998).

It is also understandable that the meanings of being male or female and therefore, the behaviour of adolescents are influenced by what is considered as 'appropriate' or 'acceptable' in a particular culture. Moreover, youth perception of danger is often minimal. The cultural ideal of youthful sexuality as spontaneous, joyful and loving (Netting, 1992), acts as a 'safety curtain' to ignore possible danger. For example, many young people believe that nothing can happen to them such as HIV/AIDS or STI's. The idea of immortality that youth culture holds in a society can somehow put aside such obvious dangers as mentioned above. In combination with these, personal identity is a factor that can influence one's decisions regarding sexuality matters. Understanding one's culture is an essential part of personal development and personal identity (WHO, 1999). This also enables adolescents to have a better understanding and respect of cultural differences that may exist among other adolescent groups. Therefore, young people can be more respective and supportive to alternative approaches on sexuality issues. Adolescents themselves may be able to contribute to the promotion of a better adolescent sexual health. No matter how important

culture and cultural differences seem to be in adolescent sexual health, this remains the most neglected area (WHO, 1999).

Data from Youth Risk Behaviour Survey indicated that Latino adolescents were less likely than African American or White adolescents to report condom use or any other contraceptive method the last time they engaged in sexual intercourse (Villarruel, 1998). Religion and gender roles have been linked with sexual behaviours among Latinos. For example, the cultural values and expectations of the female role, the cultural imperative to be a mother have been associated with positive views of pregnancy and childbearing (Villarruel, 1998). Thus, culturally appropriate behavioural interventions enhance the acceptability and effectiveness of intervention to diverse groups (Villaruel, 1995 ; Jemmott and Jones, 1993). In America, gonorrhea rates are 31 times higher among Black than among White adolescents. Birth rates at the ages 15-17 are 3.2 times higher among Blacks than among Non-Hispanic Whites (Santelli et al., 2000). Naturally these statistics should not only be explained in terms of culture but also in terms of other important socio-economic and political factors. However, as mentioned previously, many minority cultural groups suffer disproportionate levels of poverty and discrimination, both which may be considered as products of the majority culture. There is mounting evidence which links in health to poverty, something that may provide an alternative explanation of the higher level of gonorrhea and adolescent pregnancy amongst the American Blacks.

Sexual life has private and public manifestations- according to one's own culture. In most American and European countries, kissing and flirting in public are socially acceptable whilst premarital sex is also accepted by many cultural groups in these countries. In other countries, such as Saudi Arabia, these activities are still a taboo (Kottak and Kozaitis, 1999); probably religion influences the acceptability of such practices. For example, the Greek

Orthodox Christianity prohibits premarital sex, even though the Greek society tolerates this for boys but forbidden for girls (Elphis, 1987).

Religion is an important part of culture. However, in most societies there may be differences between religious and cultural values. Each culture has customs or cultural norms related to sexuality that may relate to religion but may not be inherently religious. Personal interpretation of any faith may vary from the most liberal to the most traditional. In North America monogamy is a cultural ideal (Kottak and Kozaitis, 1999), while in Saudi Arabia polygamy is a cultural norm. Furthermore, birth control for Buddhists by means of contraception is not ordinarily a problem. In Islam, Christian Orthodoxy and Catholicism premarital sex is prohibited (FPA, 1997a). In Jewish law, a man cannot use any form of contraception. However, it is assumed that women may do so (Chambers et al., 2001). According to (Chambers et al., 2001; Qureshi, 2001), in Hinduism, a male doctor cannot insert to a female a diaphragm or an Intra Uterine Device (I.U.D.) with his right hand. The right hand is reserved for eating food, shaking hands or counting money. Therefore, even though these methods of contraception are acceptable by Hindu women and they may be suitable and effective contraceptive ways, many women may be denied access to them due to lack of alternatives to right handed male doctors, in other words female doctors or left handed male doctors.

In Catholicism there is the belief that masturbation is something bad and something to feel guilty about. A number of studies reported that young people (15-19) whose religion was important to them and attended church frequently were less likely to report having sexual intercourse during adolescence (Rosenthal et al., 1999 ; Gunatilake, in Henderson et al., 1998). In Nettings' research on young Canadian students (1992), 29.6% reported religion as the main reason for celibacy. Savona-Ventura (1995) reported that the Maltese Catholic church objected to the health authorities, about the

promotion and use of barrier methods of contraception, even though the AIDS epidemic is still a major health danger. The church also objected to sterilization as a method of contraception. In contrast a research study among Nigerian secondary school students found that religious affiliations did not appear to play a role in their level of sexual activity (Amazino et al., 1997). The hypothesis that some religions may be less restrictive and more permissive on sexuality or sexual activity than others needs much more investigation.

Pregnancy in adolescence is frequently unwanted (Jejeebhoy, 2000). Most of the times contraception is not used due to several reasons, such as lack of knowledge, religion or lack of money. For some adolescent girls unwanted pregnancy precipitates marriage and for some may result in abortion. Few of them may become teenage mothers. About 12% of all Colombian adolescents had experienced abortion. In Cuba, 21% of 13-19 year old girls reported to have had an abortion during the last twelve months (Jejeebhoy, 1999). The fear of stigmatization and ostracism may lead to clandestine sexual liaisons. In China, unmarried women are 'ashamed' to purchase contraceptives due to the risk of disclosure. In many countries pregnant adolescents are expelled from schools (Jejeebhoy, 1999). Some adolescent girls may try to self induce abortion due to the fear of consequences of socio-cultural 'inappropriate behaviour'. Data from several studies worldwide show a higher risk of maternal death among teenage girls compared with women aged 20-24 years (WHO, 1993) In Jamaica and Nigeria pregnant girls under 15 are four to five times more likely to die during pregnancy and childbirth than those aged 15-19. Common complication of early childbearing include hypertention leading to eclampsia, obstructed labour (especially if pregnancy occurs soon after menarche), vesicovaginal or rectovaginal fistula may follow obstructed labour, low birth weight etc (WHO, 1993). These complications are all life threatening.

Another cultural sexuality issue, which is relevant to pre-adolescents and adolescents, is that of female genital mutilation. In several countries, such as Middle East and Africa, girls are subjected to female genital mutilation. Over a 100 million of women alive today have been affected by this, which may have immediate and long-term effects on reproductive and general health, such as infections, haemorrhage, sterility, difficult menstruation and coitus and psychological problems (IPPF, 1994). According to Alan Guttemacher Institute (1998a), 87.3% of young girls aged 15-19 in Sudan and Mali and 36% of those in Central African Republic and in Cote d'Ivoire have had female genital mutilation. The girls have little or no choice undergoing this procedure. In Egypt about three fifths of women that have undergone this experience in adolescence, intended to perform or had already performed female genital mutilation to their daughters (Jejeebhoy, 1999). Egyptian women may be 'trapped' within their own culture and may feel powerless to rebel against a practice, which many would consider unnecessary and inhumane. This confirms the concept of culture (Leininger 1995; Helman, 1994) as a set of guidelines that one inherits and transmits from generation to generation. Literature reveals arguments that circumcision is relatively advantageous to women as a form of birth control. There is no evidence though that limiting the number of one's own children is its actual purpose. Paradoxically, many of these girls and women have been six or seven times pregnant and most of these pregnancies tend to be miscarriages or stillborn infants (Boddy, in Lancaster and Di Leonardo, 1997). Female genital mutilation is part of traditional cultural practice. It is a way of life. In these cultures it is believed that female genital mutilation will prevent girls from having premarital sex and thus ensuring marriageability (Haddad, 1993). Arguably, it is challenging to find any rational reason for female genital mutilation.

Another important aspect of sexuality, which needs to be considered in cultural terms, is that of sexual orientation. Historically and cross-culturally sexual behaviour reflects sociopolitical and economic conditions. In classical Athens, there were homosexual unions between elite men, including teachers and students and this was viewed as an acceptable behaviour (Kottak and Kozaitis, 1999). The great Hindu sage Vatsyayana wrote and illustrated the Kama Sutra, celebrating sexual expression and sexual diversity without shame (Pratt, in Wilson and Mc Andrew, 2000). Some societies continue to practice and accept sexual diversity. For example, Dahomey girls of West Africa are prepared for marriage by having homosexual relations with older women (Kottak and Kozaitis, 1999). In New Guinea, as mentioned previously, homosexual relations are somehow obligatory for boys (Kottak and Kozaitis, 1999 ; Triandis, 1994).

Nevertheless, sexual diversity is a taboo in many communities all over the world. Some cultures are strongly 'gender-polarized' and hold highly traditional ideologies. They strongly differentiate roles for boys and girls, men and women. Thus, sexual orientation is directly linked to cultural definitions of masculinity and femininity in most, if not all, cultures (Lippa and Tan, 2001).

In Britain homosexuality was a criminal offence until 1967 and was also listed as a mental disorder until the late 70's. Comparisons between different cultures showed that there is no universal consensus about normal sexual behaviour (Green and Tones, in Wilson and Mc Andrew, 2000). Cross-cultural studies underlined that non-Western societies may recognize same sex activities as integral and necessary to the overall social structure (Herdt, 1997).

Cultural codes of sexual expression dictate whether an act is legal, normal, deviant or pathological (Kottak and Kozaitis, 1999). It is obvious that some forms of sexual expression are valued more in some cultures than in others. This affects sexual health as well as self-esteem and self-awareness. It also influences the communication between partners and health professionals

about one's own sexuality, sexual preferences or practices (Wilson and Mc Andrew, 2000). This is even more significant for adolescents. During their experimentation, ambivalence and search for their sexual identity, their self-esteem and self-awareness are challenged.

Adolescents have the highest risk for many negative health consequences related to sexual risk taking behaviour, including HIV/AIDS, Sexually Transmitted Infections and unwanted pregnancies (Kotchick et al., 2001).
Adolescents' sexual health problems may not be able to be eradicated but they can definitely be reduced. No country can claim that had managed to maintain the sexual activities of adolescents planned or safe from health complications (Jejeebhoy, 1999). There is no doubt that age, race, ethnicity and culture are determinants of one's own health behaviour. The enhancement of transcultural concepts seems to be of immediate need. Cultural and social beliefs affect the individual attitudes, behaviour and beliefs (Papadopoulos and Alleyne, in Papadopoulos et al., 1998). Therefore, a culturally sensitive sex education is of an obvious need (Ip et al., 2001). Any programme aimed at people's health should be culturally sensitive and appropriate and delivered by culturally competence health professionals (Papadopoulos, in Daly et al., 2002a).
Every person deserves a unique, holistic, equal and culturally sensitive health care. This not only shows respect to the diversity of cultures and the individual but it also makes sense.

Summary

Culture, as discussed in this chapter, is an inseparable part of health. One can not understand human sexuality without exploring its relation with culture and its components such as gender (see chapter 3). A holistic comprehension of adolescent sexuality it is likely to view sexuality within everyday culture and how culture influences the expression of sexuality and promotion of sexual health.

CHAPTER 3

GENDER

Introduction

As previously discussed, adolescents' sexual attitudes and behaviour are influenced by socio-cultural factors and norms. Gender as a social norm affects behaviour within one's own culture. Therefore, it is essential to explore the concept of gender and its association with culture and sexuality (especially adolescent sexuality).

3.1 Gender Versus Sex

Sex and gender are terms whose usage and analytical relations are almost irremediably slippery. Some use these terms interchangeably, whereas others highlight their differences.

Sex refers mainly to the biological categories of male and female. Of course sex is used to designate aspects of sexual behaviour. For most people biological sex is determined "...whether an egg is fertilized by an X or Y bearing sperm" (Crawford and Unger, 2000:151). This is thought to include marked dimorphisms of genital formation, fat distribution, hormonal function, reproductive capacity etc. (Kosofsky-Sedgwick, in During, 1993). In other words, sex denotes "...objective biological capacities and constraints of physical organism" (Wilson, 2000:2998).

Doyle and Paludi (1998:5), argued that biological sex is "...a continuum where reproductive structures, hormones and physical features range somewhere between two end points and not one of two strictly separate biological categories". It was also found that there is no one biological characteristic that always determines sex. The authors continue to argue that androgens, estrogens and progesterone are referred as 'male or female hormones'. In fact all of them are in one's bloodstream. Therefore, an

individual's sex is not determined by the kinds of hormone he/she has, but by the amounts of them.

Sex-differences refer to the biological properties of individuals and are sought among specific biological characteristics or assumed to be known. It is not considered that they need social scientific explanation (Hess and Ferree, 1987). Sexual differences should also be understood as a mode of discourse, one in which groups of social subjects are defined as having different sexual/biological constitutions. "One's sex is genetically determined and biologically maintained anatomy and physiology. One's gender is the enactment of sexual identity in response to socio-cultural learning" (Alt, 2001:9). Sex or chromosomal sex (as seen by some researchers) may be viewed as the relatively minimal raw material in which social construction of gender is based (Kosofsky-Sedgwick, in During, 1993). 'Gender' and 'sex' can be analyzed as modes of discourse but with different agendas" (Yuval-Davis, 1997:9).

Gender is seen as a principle of organizing social arrangements, behaviour and even cognition. One of the central elements in gender systems is the taboo against the sameness of male and female (Hess and Ferree, 1987). Gender denotes subjective features of socio-cultural roles acquired in specific cultural and social milieux (Wilson, 2000; Caplan, 1993).

Gender should be thought of as independent of a person's biological sex (Doyle and Paludi, 1998). Whatever the biological predispositions, people shape gender differences through a complex set of forces. It depends on childhood socialization and structural constraints, such as status or wealth. Therefore, gender is created through everyday interactions within specific historical, social and political configurations (Messner, 2000).

3.2 Gender and its Components

Components of gender include- gender roles, stereotypes, gender norms, gender role identity and vary along a continuum of femininity and masculinity. Gender should be understood "...not as a 'real' social difference between women and men, but as a mode of discourse which relates to groups of subjects whose social roles are defined by their sexual/biological difference as opposed to their economic positions or their memberships in ethnic and racial collectivities" (Yuval-Davis, 19997:9). The concept of gender can be analyzed and rationalized as an entity in itself. Thus, it means much more than 'social differences' between men and women. However, by each gender comprehending their differences, it results in an understanding of their similarities; their needs and capacities for change (Rhode, 1997).

Gender differences can be explained through socialization, gender identity construction, as well as existing power inequalities between men and women (Bergman and Scott, 2001). With the customary norms of everyday behaviour young women and men are helped in different situations. For example, men may receive service priority in department store, whereas women are offered helped for a flat tire. Men usually do not help more than women, when the situation called for empathy and social support (Crawford and Unger, 2000). Somehow society and culture construct the abilities and roles of each gender. Culture as a set of guidelines that are shared and learned from one generation to another (Leininger 1995; Helman, 1994) may guide individuals to adopt given roles. However, these roles may not respond to reality. In some societies differentiation of roles or discrimination begins from birth. If a boy is born there is general rejoicing, whereas if a girl is born, gloom descends on the household (UNPF, 1996). The colours that boys and girls are dressed, the rewards and punishments for each gender are learned within everyday culture also from birth.

Gender differences and behaviour might be related to the 'masculine' or 'feminine' culture one is raised and lived (or still lives). In masculine cultures (e.g. Japan, Austria), emphasis is given on occupational achievements, while in feminine cultures (e.g. Sweden), cooperation with co-workers and job security are valued (Costa et al., 2001). For example, fathers in masculine cultures deal with facts and mothers with feelings, whereas both of them deal with feelings in feminine cultures. In 'feminine' cultures gender relations seem to be more harmonious than 'masculine' ones (Costa et al., 2001). Thus, it can be assumed that sexual relations are more balanced. According to Walby (1990), masculinity entails assertiveness, being active, lively and quick to take the initiative, while femininity entails cooperativeness, passivity, gentleness and emotionality. It may be debatable whether 'masculine' and 'feminine' cultures can be classified. May be this can also creates sexism and gender inequalities. Whatever the case, culture does have an impact on the development of gender-role, gender differences as well as one's personal identity.

Most gender differences resulting from adoption of gender roles, define what is appropriate for men and women (Costa et al., 2001). *Gender roles* are learned through observations. For example, girls who watch their mother's domestic works are likely to pick up similar messages. It is important from young age to recognize stereotypical images and cross gender boundaries. This will allow young people to develop their full potential (Rhode, 1997). Most parents do not consciously encourage gender stereotypes or roles. Culture may influence though some parents more than others, thus to deliberately try and introduce specific gender roles (Rhode, 1997). Undoubtedly, parental support is a key factor that enables a boy or a girl to achieve or do whatever they want to do or achieve or are capable to do (e.g. girls success in science class).

One may argue, that today gender roles are going through changes (e.g. males are more involved with housework), but somehow many times gender stereotypes are still projected within a society in a variety of ways. Throughout the years, *mass media* presented women's physical external charismas or beauty and rarely their professional, spiritual, political or societal role. Playboy magazine published in 1953, promoted pleasures of being a male and blamed women for enslaving men. Arguably, these are reflections of social values, but at the same time they shape values. VandeBerg and Streckfuss (1992), analyzing prime-time television programme episodes found that representation of male to female characters were 2:1. Working women were less likely to portrayed as decision makers, assertive, socially and economically productive. Women in management positions presented that they inherited those from spouse or relatives. Men portrayed mainly as powerful, tough, aggressive and competitive. In United States when birth control pill was approved, a great deal of media discussion was provoked undermining the ideology of motherhood (Staggenborg, 1998).

Cultural phenomena such as television reflect and influence public sentiments about the changing roles of men and women (Staggenborg, 1998). Different movies, songs, famous persons have passed through the years their messages: From the tough masculinity of John Wayne and Elvis Presley who focused on teenage girls, to the 'Breakfast at Tiffany's' featuring new female styling and 'Thelma and Louise' showing the female abuse (rape) and rebelliousness. Although women's passive role has declined over the years, still women are more frequently presented in depicting more passive roles than men. Women in many advertisements are presented as glamorous, young and sexy figures. Adding to this, music videos are the most sexist media in representing women; 78% of the performers are male (Crawford and Unger, 2000). Since socialization also occurs outside family, media have a significant role in promoting specific characteristics of gender roles. For example, 'Marlboro' advertisements for years are presenting the Western

cowboy image, projecting masculinity, independence and power. For Americans, 'Marlboro man' even became a cultural symbol (Keller, in Dines and Humez, 1995). One may argue that 'Virginia Slims' cigarettes project a female gender role. Even if one analyzes the name Virginia- a female erotic name throughout the history and Slim- slimness that is associated with femininity, it reinforces a female gender role. It also builds up an image of beauty and sexuality. There are also 'male' and 'female' magazines such as 'Man', 'Good housekeeping', 'Cosmopolitan', 'She'. Arguably, it may be more practical or marketable to buy a magazine that both genders can find interesting things to read. It seems doubtful that reading a single-gendered magazine is more fulfilling for one's needs. Many people though may find those magazines closer to their gender image, more fulfilling. Furthermore, in advertisements in different magazines (such as Vogue or McCalls) an important 40% are depicting women as sex objects (Crawford and Unger, 2000). A recent Coca Cola commercial showed women's buttocks while working in constructions. The young men were shown to enjoy the scene having their Coca Cola drink. Several advertisements used women's body (part of it or all) to promote a particular product that usually has nothing to do with the actual product that is advertised.

Despite the influence of mass media on gender roles, Crawford and Unger (2000) suggested that more and more young people challenge traditional gender roles, which is leading towards a greater flexibility. They proposed that information and knowledge, personal and gender beliefs and attitudes shape the degree of media influence to one's own ideology.

Arguably, different forms of gender roles exist due to the diversity in gender relations and expectations consequent upon age, class, ethnicity and religion. In countries where economic development occurred and more women became employed outside home (e.g. U.S.A.), gender role ideology became more liberal (Burn, 1996). The issue of equality is still a huge debate. On one hand, many believe that women are homemakers and that is their place.

However, if all women have chosen to follow this concept, then women would never equal men in political and economic power (Staggenborg, 1998). Within a democratic society genders are expected to have equal rights. Some women choose to support feminist views (e.g. reproductive rights) and some do not; some will become political activists and some women will choose to stay at home. Although improvements have been made, there is still space for more. Nowadays, it is more common for women to choose to work outside the home and for young men being much more involved in household tasks. There is evidence though, that women still assume two-third of the domestic work (Rhode, 1997). Although this may differ from culture to culture, the current position of women in many societies is becoming more equal to men than in previous periods.

Whether gender roles are purely cultural creations or reflect preexisting and natural differences between the sexes inabilities and predisposition, is a controversial issue (Geary, 1999 ; Eagly, 1995). Some can argue that what each gender reflects is what it is in its nature. That is how was created and probably it will not change (Yuval-Davis, 1997). Biological theorists consider differences due to natural selection (Costa et al., 2001). Social psychologists believe that gender roles are shared expectations of men's and women's attributes and social behaviour and these are internalized from childhood. Other researchers accept the fact that people naturally have some gender characteristics, but how they are constructed, formed and appeared are due to cultural interactions (Costa et al., 2001).

Another component of gender is that of stereotypes. Walter Lippman noted in 1922, that *stereotypes* are "...culturally determined pictures that intrude between an individual's cognitive facilities and his/her perception of the world" (Crawford and Unger, 2000:37). It may also include the different characteristics that one possesses from birth and through the socialization process (Wilson, 1995). Furthermore, stereotypes are "...generalized beliefs

about what members of an identifiable group are like and operate as schemas, when people perceiving those groups" thus, they influence perception and memory (Burn, 1996:111). All these imply that stereotypes are created and reinforced by the way that one understands the world, which is mainly influenced by one's own cultural background. Whenever individuals are classified by others as having a particular similarity due to the fact that they are members of a specific group or category of people, stereotypes are likely to occur (Crawford and Unger, 2000). This can be unfair or unequal to most people. It can even become a racist characteristic and therefore it may distort reality. Costa et al. (2001) found that gender stereotypes were more differentiated in Western, individualistic cultures.

Stereotypes seemed to be more like forms of social consensus rather than individual attitudes (Crawford and Unger, 2000). Individual beliefs are not the same as stereotypes. For example, one may believe that because a woman wears a very short skirt that she has poor intellectual abilities. This is probably one's own opinion and perception and represents some of the women that he/she knows. There is no evidence to support that there is a relationship between short-skirts or clothing and intellectual abilities. Usually stereotypes lack of variability-most of the people choose a particular characteristic of a young group such as many believe that men are more competent in mathematics than women. This belief may influence one's own ability in mathematics. Stereotypes about males and females appear to consist in virtually all aspects of human beings (Crawford and Unger, 2000). Since gender affects perception (Burn, 1996) gender role stereotypes exist like other stereotypes. Certain role behaviours, such as being the main provider or cooking the meals or even certain occupations (e.g. secretary or taxi-driver), are associated with the male or female roles. Despite that, these examples are seen and lived during everyday life, the ideas/concepts that exist and their interrelationships affect one's perception on gender roles. "Stereotyping involves making value judgments rather than seeing realistic expectations" (Charon, 1989:202). For example, being a teacher is

anticipated to meet the expectations of a teacher position, but if one believes that all teachers are over-demanding of or punishing the children this can be stereotyping.

If one goes to a toy store, it will be clear which toys are intended for boys (e.g. cars, building tools) or girls (e.g. dolls, coffee set), but rarely for both (Burn, 1996). Gender segregation serves to reinforce gender stereotypes throughout childhood. Boys celebrate heroism, dominance, competitive activities and aggression and girls romanticism, domesticity and personal appearance activities (Rhode, 1997).

Continuous emphasis on gender differences can prevent people from seeing gender similarities. Work/occupation is often a debate associated with gender stereotypes or inequalities. Fathers who are devoted to their careers are viewed as 'good providers', while women are viewed as selfish (Rhode, 1997). In addition to this, many women may sacrifice their own career for their families or for their partner's or husband's career and most of the time no one notices.

Yuval-Davis (1997), argued that women's oppression is endemic and integral to social relations with regard to the distribution of power and material resources in the society. However the notion of 'patriarchy' is highly problematic. According to Walby (1990:20), patriarchy is viewed as "...a system of social structures and practices in which men dominate, oppress and exploit women". Walby clearly explains that she rejects the notion that every man is in dominant position or that every woman is in a subordinate position. It is also important to note that Walby highlighted different structures of patriarchy operating within different domains such as employment, culture, sexuality, violence etc. In contemporary societies gender relations have somehow changed but still need to be improved. Therefore, gender relations (including sex and gender differences) need to be seriously considered in promoting a better understanding of sexuality, culture and promotion of

health. Gender relations are at the heart of cultural constructions of social identities and collectivities as well as in most cultural conflicts and contestations (Yuval-Davis, 1997).

Within multicultural and democratic societies it is obvious that emphasis should also be given in variations in culture, class, race, ethnicity, age and sexual orientation (Rhode, 1997).

3.3 Gender, Culture and Sexuality

Gender is a cultural construct (Caplan, 1993). It detaches the social construction of sexual identities from the 'real' biological differences of sex. Cultures or societies use social categories as explanatory mechanisms of, and a means to social injustice. For example, the United States culture employs categories such as 'gender' or 'race' to privilege or restrict access to important cultural resources and opportunities (e.g. cultural authorities, jobs) and this conception might be analogous to the way of thinking of culture as a 'thing' (Allen, 1996). These categories can influence the way one thinks for him/her self and others.

Sexuality is produced and maintained within gender relations. Sexuality and gender are separate organizing features of social relations but intersect by mutually reinforcing, naturalizing and constituting each other (Schippers, 2000). Sexuality generates wider social relations and is refracted through the prism of society. Sexual feeling and activities express all the contradictions of power relations- of gender, class and race (Ross and Rapp, in Lancaster and Di Leonardo, 1997).

Cross-cultural studies showed that there are similarities in gender roles (and in relation to sexuality) among the different cultures (Burn, 1996), but still they can vary in the way that these similarities are viewed. However, it is difficult to determine whether similarities are indicative of evolutionary factors or whether they reflect common practices or solutions that humans use in a particular culture (Burn, 1996).

According to Williams and Best (1990), men and women in more traditional cultures (that hold their beliefs, customs through-out centuries e.g. Pakistani culture) emphasize sex role differences, but in modern cultures (e.g. Dutch culture) minimize them. Therefore, cultures may vary in the degree to which sex roles are emphasized (Costa et al., 2001). In Kikuyu, Kenya coitus is seen as a necessity for health and sanity and anyone who does not have

regular sex will suffer various illnesses. Wives are not allowed to touch their husbands' genitals and husbands to touch their wives' nipples. The man has to be on top of the woman. Kikuyu men believe that they need a lot of sex and a variety of sexual partners. It is a man's right. Faithfulness is not an issue for men, as it is for women (Caplan, 1993).

Even though Munroe's et al. (1984), research in four cultures about gender understanding and sex role differences is not a recent one, it is interesting to mention some of the findings: The Logoli of Kenya and the Newars of Nepal displayed strong emphasis on sex differentiation in socialization practices and institutional characteristics, while the Garifuna of Belize and the Samoans of American Samoa did not. The Kenyan and Nepal cultures induct young girls into domestic labor force at significantly higher roles than young boys, producing experiences that are sharply sex differentiated. Young males have a transition period to adulthood through various initiation rituals. Females are required to get married and move near the kinsmen of their husbands. Cultural characteristics of this sort have been linked to the development of several elements of sex-appropriate behaviour. In Belize and Samoans cultures girls and boys have nearly equal societal role. The differences of sex roles found in Munroe's et al. (1984) study are due to cultural and cognitive factors.

In some cultures, gender differences may be exaggerated, in others they may be masked (Costa et al., 2001). When people from Argentina, Peru, Ecuador, El Salvador, Mexico, South Africa, Pakistan were asked in Kate O'Neil's study in 1994, what would happen to a child if he/she does not behave as expected of his/her sex, all of them responded that he/she will be punished through ridicule, teasing and even physical punishment (Burn, 1996). This is surprising considering the diversity of the people in the countries, which participated in this study.

According to Caplan (1993), many Muslims' attitude to sexual intercourse follows, the Koran rules- 'women are your tillage'. Sexual intercourse is a pleasure (for men) and should be enjoyed as such. Women are thought to be sexually enthusiastic and irresponsible given the opportunity. Since 'men are in charge of women', they must be confined and ordered by men for sexual intercourse or any sexual matter. Some men also believe that menstrual blood pollutes (Caplan, 1993), therefore any contact should be avoided on those days. An admirable man is a person who supports and controls women and children (Caplan, 1993). Nevertheless, there are many interpretations of the Koran and different Muslim groups may understand or apply it in different ways. Arguably, the woman's societal position/role as subordinate is adopted by many Muslim communities. Different religious groups may interpret religious books (e.g. Koran, Bible) according to their needs and understanding. A similar division of norms has been reported among Greeks in rural areas (Loizos and Papataxiarchis, 1991): Among Greeks 'shame and honor' are very important; it is a matter of prestige. Marriage is regarded as a necessary condition of the continuation of life. Women are perceived as 'mothers', ' house-mistresses' and 'wives' (Loizos and Papataxiarchis, 1991). Somehow, women are called to serve all the needs of their husbands as well as the family needs. There are the extreme cases also- Palestinian women have been murdered by their male relatives because they brought 'shame' on their families and community. Women must have 'proper' behaviour (Yuval-Davis, 1997), in everyday culture, such as clothing, talking, sexual activity. Such 'honor killings' continue to take place in a number of third world and developing countries.

Differences in power relations between women and men influence one's own behaviour for sexual health. For example, whether women can purchase or use a contraceptive and their vulnerability to STI's. In Zimbabwe when a wife learned of her husband's infidelity, a health professional suggested that she should insist that her husband use condoms with her in the future. Her

reaction was interesting. She underlined that this would lead to the end of the marriage or even violence. This emphasizes the husband's dominant power in the marriage (Mafethe, 1995). It is obvious that in many cultures male gender power is so strong that women are willing to be without protection, despite the knowledge of the dangers to their health, even possibly death (HIV/AIDS). Knowledge is power; knowledge unused is not. Power comes with the confidence and ability to use this knowledge (Mafethe, 1995). This supports Foucault's idea of knowledge and power and the connection of the knowledge with identity (see chapter 2). Nowadays, culturally and gender specific knowledge on sexual and reproductive health is a demand especially for adolescents.

Everyday culture includes all these challenges that one should filter carefully and then adopt, if an individual wishes to do so. Sometimes, though, is not a matter of choice. In cultures with strong beliefs and practices is hard for anyone to decline or diverse from them. According to Moghadam (in Parker et al. 1992), in Afghanistan during traditional and tribal arrangements women are regarded as men's property. A woman has to get married since her standing is maintained primarily through bearing sons. Her family chooses for her a close relative or an old man to be her husband. Women never ask men for their whereabouts or expect marital fidelity. These beliefs and practices have a direct effect on women's sexual health. For example, they deny the woman's sexual and reproductive health rights; marriage with close relatives may cause birth defects; domestic violence may be endured by women who are powerless to do anything about it as they are considered the 'property' their husbands.

In all cultures the ceremony of wedding is based on certain beliefs and practices. They may be similar to many societies, but still certain rituals or religious practices can have different meaning or importance to the particular people.

Moreover, in polygamous societies males are encouraged to be 'successful', by having more wives and children (Burn, 1996).

In the case of fraternal polyandry (several brothers married to the same woman), in Northwest Nepal, women have to move to their husbands' land and must work too. Even though people do have the option of monogamy, they prefer polyandry so that their land will not be divided (Triandis, 1994). The inferiority of the woman and the impact on her sexual health is obvious. For example, many concurrent sexual partners may lead to several health problems such as infections (e.g. urinary track infections) or some forms of cancer such as cervical cancer (Pratt, 2000; WHO, 1992). Also, there is increased possibility of many pregnancies and many children to rear (may be from different fathers). This can affect a woman's well-being. One can argue, that women are mainly seen as hard workers and sex objects and not as female entities. In societies where women are viewed as subordinate to men, sexual beliefs and practices incorporate this subordination. This can be expressed through a variety of ways such as images, scientific models of knowledge, pornography and/or law. All these factors produce or develop sexual meanings. Sexual meanings are culturally and historically specific, thus continuities and variations can be expected (Thomson and Scott, 1990).

Research has shown that male gender roles in most cultures may lead men to ignore their health needs and consequently their sexual health needs (Lloyd, 1997). This is due to several reasons: Men are more likely to engage in risk health behaviour such as alcohol, drugs or unprotected sex (Alt, 2001 ; Lloyd, 1997), they utilize health care less frequently than women (Alt, 2001) and rarely follow a preventative health behaviour. One can argue, that all of the above are consequences of the male gender role stereotypes and role models that one has. To demonstrate physical strength traditional masculinity encourages a man to disregard pain or act in hypersexual ways or to demonstrate fearlessness thus exposing themselves to more risk-taking (Alt, 2001). Nowadays, young women are exposing themselves to increased

health risks too. For example, in Western societies there is a gradual increase in smoking and unprotected sex with multiple partners among young girls. Alt (2001) argued that the present model of male gender in America generates a self-destructive health behaviour. This is because traditional masculine stereotype (as previously mentioned) has to demonstrate presumed superiority characterized by physical strength, fearlessness and self-reliance. Lance Amstrong's (multi-time winner of bicycling's grueling Tour de France) attitude towards his health, almost caused his life. This is a strong example of a typically male health attitude especially to sexual health. Lance Amstrong was diagnosed with metastatic testicular cancer. Even though he married and became a father, he did not seek medical attention until he could no longer ignore serious symptoms (e.g. swollen testicles), (Alt, 2001).

Beyer et al. (1996), argued that in middle and high school sexuality curricula that they had examined, males were represented as perpetrators of sexual exploitation, while females were portrayed as the victims of exploitation, abuse, assault and rape. Beyer et al. (1996) researched fourteen United States school curricula published during the period between 1985-1995. The study examined differences in gender representation in illustrations, photographs, cartoons, drawings and text. It is of particular concern that gender inequalities and inequities may exist in school curricula that suppose to broaden knowledge and promote health. Further, gender role stereotyping in sexuality education curricula was noted by Beyer et al. (1996), in relation to parenting which had a pro-feminine slant. The male role in parenting was omitted. The researchers suggested that qualitative research can enrich their study identifying factors that may contribute to gender differences in sexuality curricula such as gender of authors, gender of instructors and students. Doyle and Paludi (1998) found that gender roles were encouraged by parents who teach their children gender-related behaviours (e.g. boys do not cry, play football, girls do dishes) by reinforcing or punishing the children's gender-related behaviour. Perceptions, attitudes and therefore behaviour is being

recycled. Alix (1995) argued that stereotypes tend to be resistant to change, even when shown by factual evidence to be in error.

It is a major challenge for anyone to develop culturally sensitive prevention messages and thus, enhance the sensitivity to dangerous effects of sex and gender norms within cultures (Gomez, 1995). A deep understanding of health-related beliefs and practices and of human sexuality precedes the need to study each person within his/her own culture and gender.

3.4 Adolescent Sexuality: Gender and Culture

Adolescent sexuality is affected by socio-cultural factors. Values and attitudes of the family, religion and generally one's own culture about sexuality affect one's behaviour. Seventy-five percent of the American girls strongly believe that their personal worth is assessed by the way they look (Ferron, 1997). This is part of one's own sexuality, a search for an identity and gender role due to the body changes during their transition from childhood to adolescence. Bodily changes influence adolescents' health behaviour (Ferron, 1997). A sexy and attractive body is highly valued in American culture. This can be a pressure for adolescents. It may be seen (by adolescents) as a societal expectation. Arguably, self-esteem and self-awareness may be considered as strong assets in resisting temptations and avoiding unhealthy behaviours during adolescence such as having sex just for 'testing' or 'proving' their attractiveness. Seventy-five percent (75%) of American adolescents and a 25% of French adolescents reported that being attractive is extremely important to their social integration, for either friends or lovers. Bergman and Scott (2001), highlighted that British girls reported lower self-esteem compared to boys. They also reported greater unhappiness and more worries. In their research they found that self-esteem, self-efficacy, happiness and worries are more interconnected for adolescent girls than for boys. Failure to attract the opposite sex can create a feeling of negativity (Bergman and Scott, 2001). Adding to these, there is a strong association between gender role conflicts, low self-esteem and anxiety (Lloyd, 1997).

Often young people are influenced by the assumption of the roles that are imposed on them (e.g. a woman does not know how to change a car tire). Maleness conveys more power (Crawford and Unger, 2000). Cultural and social construction of gender influences this attitude. Therefore, adolescents learn throughout daily interactions that being a male is not only different from being a female but also preferred (Hand and Sanchez, 2000 ; Thorne, 1993).

According to Dowsett et al. (1998), even though all seven developing countries that they included in their study reported similar differential in cultural understandings of young women's and young men's sexuality, there was a marked perception that young men are sexual beings and young women ought not to be. With this logic, young men 'as sexual beings' need to find partners. So, if young women are not 'sexual beings', then young women are used as 'tools' or 'means' for sexual pleasure (questioning the men's sexual pleasure). Then, the persons involved seem to have no value. In some societies female stereotypes such as adolescent girls 'let sex happen' or 'trust in love' still exist. Although this view is not widely accepted, it can disempower adolescent girls with their relationships with men. Some people may believe that 'real sex' involves vaginal penetration and male orgasm and this can make some adolescent girls vulnerable in engaging to sexual intercourse without their choice (HEA, 1998). This vulnerability can influence the personal identity of adolescent girls, including their level of self-confidence, assertiveness and self-awareness. These beliefs or attitudes may have serious health consequences such as STI's, unwanted pregnancy; such disempowering values may result some young women to have self-destructive behaviour (e.g. abuse of alcohol or drugs) or 'accepting' violence by men.

Heise (1999) argued that violence is a significant part of young women's sexual lives. One-third of all female homocide victims are killed by a husband or boyfriend (Rhode, 1997). When Michael Tyson defended himself for the accusation of date rape, he said "...I didn't hurt anyone- no black eyes, no broken bones" (Rhode, 1997:122). It could be argued, that boys are socialized to be aggressive and powerful (WHO, 1999). However, this may differ from one culture to another. Latino adolescent females are more likely to be sexually abused, at even a younger age, and the abuser is more likely to be a relative (Pastore and Diaz, 1998). In early ethnographic studies of Latinos it was found that family life promoted the themes of 'machino' of men

and the passivity of women (Doyle and Paludi, 1998). WHO (1999), argued that boys should be empowered to reject 'machino' attitudes. In addition to these, girls may choose to be less assertive in order to be more likeable among their peers (Crawford and Unger, 2000).

In many societies, cultural norms about the meaning of sexual activity for adolescent girls and boys influence condom use. It is more socially acceptable for adolescent boys to desire sex, while girls are encouraged to stay virgins as long as possible (Nahom et al., 2001). Gender differences are obvious even in modern Western societies. Both genders seek and need information and knowledge related to sexual and reproductive health (e.g. STI's, pregnancy). Despite this, adolescent girls reported that were more uncomfortable discussing certain issues such as sexuality and contraception, whereas boys reported that they were more uncomfortable discussing drugs and alcohol use (Ackard and Neumark-Sztainer, 2001). Van den Akker et al. (1999), reported that more adolescent boys than girls did not know what contraceptives were and thus, they were unable to discuss it with their partners. It has been reported that adolescent girls were more likely than boys to ask their mother than their father for any health related issue. Adolescent girls, also, were more likely than adolescent boys to ask another adult female relative or a friend. However, girls tend to believe their friends more than boys and were more concerned about friends' negative opinions of their sexual activities (Van den Akker et al., 1999). Adolescent boys were more likely to consult a teacher, doctor or a nurse or no one (Ackard and Neumark-Sztainer, 2001). This shows that adolescent girls worry and want to know about their health, even though they do not often ask the most appropriate person, whereas adolescent boys seem to seek for a professional opinion. Obviously, parenting has an important impact on gender role development. In addition to these, parents are rated as having more influence on sexual attitudes. Sexual permissiveness and intercourse are related to parental discipline and control (Werner-Wilson, 1998). Adding to these, WHO (1999)

reported that adolescent boys may be consulted by their parents when important family decisions are made, while the same may not be true for adolescent girls. This creates more insecurity among adolescent girls.

Parents also must have the necessary background as to provide knowledge to their children. For example, although Latina mothers wanted to provide information about sexuality to their daughters, they lacked knowledge about it such as contraception (Villaruel, 1998). However, the promotion and use of contraception or the concern of any aspect of sexuality may differ between genders but also from one cultural group to another. For example, the rate of oral contraceptive use of U.S. Puerto Ricans is higher than that of Cuban-American adolescent females and slightly lower than in the Mexican-American adolescents (Pastore and Diaz, 1998). Several factors may influence this cultural phenomenon- health services, availability of oral contraceptives, financial constraints, personal and cultural beliefs and attitudes, knowledge and information.

In some cultures (e.g. Pakistani), parents or other elders in the family choose potential brides and grooms for their children. Many adolescents accept the decision of their family believing that since they are young probably they may make a decision that may lead to an unhappy marriage (Friedman, 1999). This idea is not totally rejected as far as the adolescent boy or girl honestly agrees with his/her parents' decision. It depends on their level of maturity. Adolescents may not have that choice though. Many times the selection of a bride or a groom is based on money, religious beliefs, age (older usually for girls) or relationship of families (e.g. relatives). There is evidence though that divorce and broken families are often seen in societies where parents or family play little or no role in choosing mates for their children (Friedman, 1999). Arranged marriages have also been and are still been practiced in many Western societies amongst the aristocracy and high social classes. The rationale for this is not very different from that being used in some developing countries where arranged marriages are a regular event. One may argue, that may be adolescents with arranged marriages in the developing countries do

not easily decide to have a divorce due to fear of family or stigmatization by society. However, this is not so for marriages in the Western societies, where divorce is much more easily decided because there is minimal fear of consequences and stigmatization.

Adolescents often confront changing cultural contexts, even as they strive to make individual choices between the cultures of parents and peers. Life events become more complicated for adolescents, whose parents differ in their ethnicities or cultural practices (Michaud et al., 2001).

Villaruel (1998) reported that in Mexican- American and Puerto Rican cultures kissing (not French kiss) was an accepted way to show affection to a steady boyfriend. Prolonged 'touching' or 'rubbing' were not acceptable though. When a girl is allowed to see a boy, he has to go to the house, her parents will meet the boy and/or his family and dates will be supervised. This is done as a protection for their daughters from 'culturally inappropriate' influences such as sex.

Virginity is very much highly valued in many cultures such as Mexican-American, Puerto Rican, Middle East, some Mediterranean countries and that is why the issue of virginity arose in many studies. It is a guarantee of the value of a potential partner. The virgin of Guadalupe (the 'brown virgin') symbolizes proper servility and modesty for Mexican women (Zavela, in Lancaster and Di Leonardo, 1997). In Cambodia young men still demand a virgin bride (Dowsett, 1998). The paradox is that it is acceptable for them to be sexually active before marriage. Socio-cultural norms that promote virginity in girls underline girls' ignorance about their bodies. This often compromises their adoption of safer sex options and use of reproductive health services for fear of being stigmatized as sexually active (WHO, 1999). Arguably, the high value that is placed on female virginity can be seen as a form of sexism or gender inequality. It also promotes the stereotyping of females as being subordinate to males. Virginity can be a choice for young women as it is for

most young men. Personal, ethical and moral values can be seen in one's own personhood and behaviour. According to Amazino et al. (1997), among Nigerian secondary school students, it was shown that the proportions of 14 and 15 year olds who were sexually active were lower among girls than boys, and of ages 17-19 (in secondary school) were higher among young women compared to young men. Similar findings were reported by Nahom et al. (2001), related to the age of initiation of sexual activity according to gender. Compared with college women, a greater proportion of young men have had many and multiple partners. They also had greater likelihood of using alcohol or drugs before intercourse. Therefore, there are serious indicators of greater sexual health risk among young men than young women (Forrest, 2001). However, young men may claim different sexual activities or behaviours that are not quite real, since it may be argued that this is considered as a gender norm. Female adolescents are at disproportionately increased risk of developing STI's due to physiological factors (e.g. immature cervix) and social factors (e.g. lack of assertiveness, pressure to agree to sex).

Adolescent males are less inclined to consider affection as a precursor to sexual intimacy than are adolescent females. There is also a positive correlation between expectations of sexual intercourse and length of relationship for adolescent males, but not for females (Werner-Wilson, 1998). Adolescent girls' identity may be more bound up with their relationships with others than in the case of adolescent boys. Adolescent girls' are likely to be more sensitive than adolescent boys to the perceptions of others (Bergman and Scott, 2001). This makes it more essential for adolescents to know and shape attitudes and beliefs for sexuality matters, especially related to gender. Many times, adolescent boys or girls concentrate only to what his/her gender 'suppose' to do/behave and do not consider knowing and understanding the needs or interests of the other gender.

In Van den Akker et al. study (1999) young women reported to be most likely to decide to have sex if they felt in love (93.5%), rather than out of curiosity (23.5%) or because they liked the person (53.2%). Young men reported also

that their decision to have sex was based on being in love (76.3%), rather than curiosity (47.7%) or because they liked the person (69.9%). Adolescents are more likely to behave in gender role stereotyping ways when on a date than when alone (Doyle and Paludi, 1998).

Young men are encouraged to think about sex in terms of their own needs and desires rather than in relation to women's sexuality. Even among intellectually empowered women that know about safer sex, only few of them report to be able to negotiate it in practice (Holland et al., in HEA, 1998). Successful masculinity is linked with the numbers of sexual encounters and sexual performance rather than the ability to be responsible of one's own sexual health (HEA, 1998). This is a major obstacle for the prevention of teenage pregnancy and the understanding of young girls' gender role and needs.

Not all cultures agree with the idea of the existence of two genders- male and female. In North American Indian societies some men are berdache- biological males who adopt the clothes and some other women roles and have sexual relationships with men. These men's behaviour fit no ethnocentric norm such as homosexuals, transvestites or transsexuals. Not all homosexuals are berdaches (Crawford and Unger, 2000). The term berdache maybe used for females too (Roscoe, 1998). In Mombasa, Swahili boys (mixed blood Arab-African), may have their first homosexual experience at puberty, while girls must be married before any adult activities are allowed to them (Caplan, 1993).

Homophobia among adolescents may lead to practice risky behaviours among heterosexual adolescents (Rios-Ellis and Figueroa, in Henderson et al., 1998). Westerman and Davidson (1993) in their study reported that the more homophobic an adolescent is, the more is to believe that HIV/AIDS is a gay disease and feel invulnerable to infection. They also reported (as cited by Rios-Ellis and Figueroa, in Henderson et al., 1998) that the degree of

homophobia positively influences the adolescent's intention to engage in sexual intercourse, after knowing his/her partner for a short time. There is evidence that adolescent experiences have a pronounced influence on adult life (Bergman and Scott, 2001).

Considering sexuality issues within different cultural perspectives in promoting health, empowers each individual in the participation in decision making, developing skills and acknowledges the importance of one's own sexual and reproductive health needs by shaping attitudes, beliefs and behaviours. These may be learned and practiced through health promotion. There is an effort to reach adolescents broadly while maintaining cultural sensitivity (Michaud et al., 2001), by involving adolescents in designing and developing studies related to sexuality, gender and cultural issues. It is essential to avoid discrimination or gender inequalities or inequities and promote cultural pluralism and understanding of health issues related to gender and sexuality.

Summary

Gender is part of culture. It influences and is being influenced by it. As gender roles have an impact on the formation of one's own identity, consequently may affect the formation and expression of sexuality. This chapter has discussed the relationship among gender, culture and sexuality (especially for adolescents). The following chapter will explore the concept of sexuality.

CHAPTER 4

SEXUALITY

Introduction

Human sexuality can be explained and understood through socio-cultural processes and meanings. In this chapter the concept of sexuality will be explored, and discussed in relation to politics, policies and relevant theories. Since education for sexuality is a challenging issue for many researchers this will also be explored along with some theoretical approaches on learning about sexuality.

4.1 Sexuality

For some **Sexuality** clearly means the physical act of sex whilst for others it means more than that. Even though researchers have not unanimously agreed upon a definition, some of them are more commonly used than others (Rivers, in Morrissey, 1998).

"Sexuality is an essential part of ourselves, whether or not we ever engage in sexual intercourse or sexual fantasy, or even if we lose sensation in our genitals because of injury" (Nevid et al., as cited by Rivers in Morrissey, 1998:61). Fogel (as cited by Pratt, in Wilson and Mc Andrew, 2000:1), states that sexuality is "...an important dimension of the human personality and is an inextricably woven into the fabric of human existence". It is essential to realize that human sexuality is dynamic and a human rather than a simply biological fact (Morrissey, 1998). Arguably, the sexual act is an important part of human sexuality but other factors (as previously discussed) are just as important. SIECUS (Sexuality Information and Education Council of the U.S., 2001:1), gives a very simple definition of sexuality. It includes "...the way one feels that he/she is, his/her body, the feeling as a boy or girl, a man or woman, the way one dresses, moves, speaks. Also, the way one acts and feels about other people. These are all parts of who someone is, from birth to death". All these

definitions, even though expressed differently, agree in at least one important point- that sexuality is a part of one's self within the everyday life. Therefore, sexuality is a natural and healthy part of one's life. People express their sexuality every day by the way they relate to others (friends, family, co-workers). It is expressed in the way one talks or dresses. Sexuality is evident in what one believes, how he/she behaves and looks (Poorman, 1988).

Sexuality -its formation and expression- has existed since the creation of the world. The images of Adam and Eve represented the meaning of human eroticism. This is how sexuality was understood in its earlier usage. Through the period of antiquity Greek and Roman cultures emphasized sexuality and sexual relations. Although there were variations between these cultures four features remained constant (King, in Porter and Teich, 1994):

a) The expression of sexuality was based on inequity in male-female relationships and between male partners in a homosexual relationship.
b) Male homosexuality was seen to some extend as normal. Usually these relationships were between young boys and an older mentor.
c) Too much importance was given in penetration. This was one of the reasons that female homosexuality was seen outside the realm of sexuality.
d) Women were seen as objects. Pandora in Greek mythology was made by the Gods for men.

Sexuality had been silenced in the Middle Ages and in the Victorian era through Christianity. It was believed that women could not enjoy sex and this was a role to be endured within marriage; thus prostitution flourished (Sobolewski, in Morissey, 1998). There was much social suppression of sexual feelings and expressions and it was almost up until 19th century, that the word sexuality came into common use in Europe and America whilst at the same time its meaning was being reshaped.

Many people, even today, believe in myths and/or have misconceptions about sexuality that often have been perpetuated by parents, friends and culture in general. Therefore, attitudes, beliefs, behaviour and expressions of self in relation to sexuality (e.g. sexual identity, orientation, feelings, gender issues) are influenced by cultural beliefs. Milligan (1993), argued that sexuality is a cultural production: it represents the appropriation of the human body and of its psychological capacities by an ideological discourse. This cannot be said for sex too. Sex is just a natural fact, grounded in the functioning of the body. Therefore, it lies outside culture. From one point, this can be understood and one may think how poorly people actually value sexuality, while most (if not all) the emphasis is given to the notion of sex. Even though sex is a biological drive it could be argued that the way a person behaves to another, expresses his/her feelings or no feelings at all during sex, is highly influenced by culture.

Freud and Sexuality

Freud proposed a developmental model of sexuality, where an infant progressed through the oral, anal and genital phases to reach sexual maturity (Hass and Hass, 1993). It is widely accepted by many psychologists that Freud's theory of sexuality had a major impact in the understanding of human sexuality (Horrocks, 1997). Freud argued that adult erotic predilections are in the majority determined by infantile development (Horrocks, 1997). There is no doubt that childhood experiences influence adulthood life. Freud never abandoned the biological basis of the instincts and indeed of psychology (Horrocks, 1997). This, as well as the fact that he gave little importance to the role of the environment and that of learning, was criticized by some researchers, (Antonopoulou, 1999).

Cultural norms influence the capacity of men to experience sexual pleasure. Freud argued that a man can not develop full potency unless there is 'a debased object', meaning a woman with whom he will be comfortable with.

Chodorow (1994) argued that with the use of subject or object, Freud described how men experience, characterize or imagine women. She goes further to mention two limitations of Freud: "... first, the maternal- as strong, intense feeling, preoccupation, and identity in women as subjects- is almost absent; and second hegemonic... is an account of mature female desire and heterosexuality that renders them as inhibited at best; at worst, female desire and sexuality are seen entirely through male eyes" (Chodorow, 1994:4). It can be argued, that much more emphasis should have been given to a holistic view of the woman as a human entity; and on maternal identity. It is important to note that Chodorow highlighted the importance in understanding the social or cultural subject or self. This may provide a better insight of female or generally human sexuality.

Furthermore, Freud's idea that women suffer 'penis envy' due to weak superegos are now discounted by many psychologists and some even consider it as a sexist idea (Myers, 1989). All males and females seem to relate to the male organ (Gilman, in Porter and Teich, 1994). Two of the main foundations to Freud's exploration of sexuality are the Oedipus complex and the Castration complex. Even though this seems to serve masculinity well, is not the same for femininity (Bristow, 1997). Some criticized Freud as a misogynist. According to Freudian theory, if these complexes are 'positively' experienced this will lead to heterosexuality. Freud in his theory of identification argued, that children's identification with same-sex parents, lead in adopting his/her characteristics. Therefore, this process provides one's gender identity. However, many researchers opposed to this theory emphasizing that children may become strongly feminine or masculine even in the absence of a same-sex parent (Myers, 1989).

Foucault and Sexuality

Sociological theorists aim to articulate human's universal condition (Seidman, in McQuarie, 1995). They view sexual behaviour as an aspect of social behaviour or the interaction between two or more people that coexist within a social space (Antonopoulou, 1999). Undoubtedly norms and values of each society influence sexuality and sexual behaviour. Some even argue that the cultural specific sequence of sexual behaviour is learned by each individual (Antonopoulou, 1999).

According to **Foucault** (1984:34), "...the use of the word sexuality was established in connection with other phenomena: The development of diverse fields of knowledge, the establishment of a set of rule and norms, which found support in religious, judicial, pedagogical and medical institutions; and changes in the way individuals were led to assign meaning and value to their conduct, their duties, their pleasures, their feelings and sensations, their dreams". One could say, that what Foucault discussed is that one's understanding and expressing sexuality depends on the influence of socio-cultural determinants such as religion and on one's personhood or personal identity. Foucault argued that sex is not a biological fact but a historical construct (Hoy, 2001). He tried to understand and explore the correlation between fields of knowledge, types of normality and forms of subjectivity in a particular culture. For example, Foucault argued that in ancient Greek culture where Greeks loved boys, reveals that there was a problem; otherwise, they would speak of love in the same terms as love between men and women. Foucault goes further to say that Greeks could not even imagine reciprocity of pleasure between a boy and a man (Rabinow, 1984). What Greeks say about this love of boys implies that the pleasure of the boy was not so important and that it was dishonorable for the boy to feel any pleasure in relation to the man (Rabinow, 1984). As viewed just above, ethics of pleasure and the understanding and/or expression of sexuality are influenced by the society and culture. Thus, one's understanding of sexuality is related to social self.

Sexual attitudes, according to Foucault, are influenced by the prevailing culture or ideology. Therefore, sexuality is 'discursively constructed' (Windschuttle, in Nola, 1998).

Foucault confronted the everyday notion of sexuality, analyzing its theoretical and practical content. "The essential features of sexuality correspond to the functional requirements of a discourse that must produce its truth" (Foucault, 1984:68). Foucault claimed that the most powerful and persuasive sexual discourses are those that are taken-for-granted as being unimportant (Evans, in Morrissey, 1998). He emphasized informal discourses such as gossip and humour innuendo; cultural forms such as these form powerful constraints on how one understands and behaves in everyday life, including sexuality, (Evans, in Morrissey, 1998). However, other constraints also exist; for example law, morals, ethics.

Ethical problems, according to Foucault, are not necessarily related to scientific knowledge (Rabinow, 1984). Michael Foucault argued that for an action to be moral is more than just conforming to law or rule. It involves a relationship with the self, meaning not simply self-awareness, but self-formation as an 'ethical subject'. This requires one to act upon one's self, to monitor and to improve (Foucault, 1984). Culture along with one's self have a strong impact on understanding morals and ethics. As Windschuttle (in Nola, 1998) argued, the concepts of self-mastery or self-control do not operate in the absence of cultural influences. Erotics, according to Michael Foucault, imply self-mastery and self-control. The way that the power of eroticism is distributed, mediated and produced comes from within culture (Bristow, 1997). Foucault focused on the way that power mobilizes itself rather than through the operation of power by people (Hoy, 2001).

Many researchers have been problematized with Foucault's ideas. He refused to employ the dialectical materialism of Marx or to affirm the psychological realities elaborated by Freud. Some argued that, this skepticism of other researchers regarding Foucault's ideas is because he presented an alternative to traditional consensus directed at revealing one's

own assumptions (Baert, 1998). Nevertheless, the fact that sexuality with its components has been the subject of an overwhelming explosion of discourse is highly valuable.

Sexual and Reproductive Health

At this point it is important to distinguish between *sexual and reproductive health* and *sexuality*. Different researchers have a variety of approaches to these concepts. Some use these concepts interchangeably.

According to WHO (1994:5) reproductive health "...implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".

Even though a long definition, it clearly states the importance of reproductive health, as well as the freedom and choice to reproduction. Indirectly it highlights sexual and reproductive health rights (these will be discussed later in this chapter) but not sexuality.

Recently, the British Department of Health (2001:5) in its Strategy for Sexual Health and HIV refers to sexual health as "...an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfillment with access to information and services to avoid the risk of unintended pregnancy, illness or disease". This definition goes a step further from WHO's definition. It gives a psychosocial view of sexual health. Nevertheless, it can be argued that the notion of sexuality

could have been emphasized even more, especially its socio-cultural determinants. In the Strategy there are some references to sexuality but it mainly concentrates on sexual health.

Hill (in Morrissey, 1998:46) argued that one can conceptualize sexual health as:

a) an instinctual drive that, left unfettered, will automatically result in the development of a healthy sexuality.

Freud for example, viewed sexuality in terms of instinctual forces and suggested that if individuals live unfettered then, according to Soble (as cited by Hill, in Morissey, 1998), sexuality would be developed undistorted and healthy.

b) a practice that is series of activities, which can be defined, usually on moral grounds, as sexually healthy as opposed to unhealthy.

It is difficult though to draw a line between healthy and unhealthy. Baker (cited by Hill, in Morissey, 1998) problematized for example, whether anal intercourse is a natural form of birth control. Another challenging argument is whether sexual abstinence is healthy sexuality or not. Sex can not be seen as a set of practices because the erotic and the fantasy often precede the sexual act (Hill, in Morrissey, 1998).

c) a physical state; namely the condition in which a person minimally has an absence of disease, or is able to perform their sexual function adequately according to their current developmental stage.

It is difficult to discuss for the physical conception of sexual health having in mind that everyday life is more than just a physical state. However, conditions that may physically distort sexual activity such as HIV/AIDS can not be ignored.

d) a mental state, in which the individual conceives self or others in terms of sexual categories. This may be influenced by one's mental self and whatever others may identify as sexual.

e) a state of social well-being in which the liberation of society is the mirror image of the liberation of the individual. Arguably, one's own sexual practices and manifestations are influenced by the world he/she lives in.

It could be argued, that sexuality and biology appear to be inextricably linked. Not just because one exists 'as', 'with' and 'in' one's body, but because sexual feelings are represented and understood as expressions of our biological constitution. Yet, somehow the idea of sexuality is an ideological imposition upon the body, that is a social construction (Millingan, 1993).

Every human being has the right to sexual health. International Planned Parenthood Federation (IPPF, 1997: 1-2 and 1996b: 11 ; Appendix No.2) highlighted its importance through the introduction of sexual and reproductive rights. This is a combination of the reproductive rights that were discussed at the 4th World Conference of Women in Beijing in 1995 and at the World Summit for Social Development in Copenhagen in 1995. These include:

1. the right to Life
2. the right to Liberty and Security of the Person
3. the right to Equality, and to be Free from all forms of Discrimination
4. the right to Privacy
5. the right to Freedom and Thought
6. the right to Information and Education
7. the right to Choose Whether or Not to Marry and to Found and Plan a Family
8. the right to Decide Whether or When to Have Children
9. the right to Health Care and Health Protection
10. the right to the Benefits of the Scientific Progress
11. the right to Freedom of Assembly and Political Participation
12. the right to be Free from Torture and Ill Treatment

This Charter is neither surprising nor unprecedented. It emphasizes the relationship between sexual and reproductive rights and human rights. Each statement elucidates the right as it has been stated and decided by international organizations related to human rights. IPPF (1996b) recognizes the importance of a positive environment in which anyone can enjoy human rights, including sexual and reproductive health rights. Sexual rights are in fact human rights (Kosumen, 1997). Still every day in all cultures, at some point, they are violated. Politics, laws and culture are major influencing factors on how such rights and guidelines are applied. The purpose of this Charter is to promote and protect individual's sexual health and freedom within all political, economical and cultural systems. It is essential that diversity of each culture be seriously considered in every aspect of human sexuality.

Life skills programmes for adolescents are designed to facilitate and promote respect of reproductive rights. Educating people, helping them to become assertive is one thing, politicizing and legalizing is another. This is an aspect that health educators should seriously consider and grasp any chance to promote sexuality education.

4.2 Sexuality, Politics and Policies

"Sexuality embraces many aspects of human existence such as the economic, social, political, psychological, emotional, spiritual, physical and genetic. Therefore, it seems difficult to develop a one-dimensional or monistic theory of it" (Horrocks, 1997:1). Sexuality is culturally and politically constructed. Nowadays, sexual health is very much on the political agenda (Jamieson, 2001). The socio-cultural, economic, political and health changes worldwide, made governments to see sexuality as a serious matter for political discussion. For example, issues like sexual orientation or teenage pregnancy often drive the attention of many people. Everyone is affected by what policy or law exists on health education and sexuality issues- schools, media, organizations and families.

Since politics is a social institution that distributes power and organizes decision-making (Macionis and Plummer, 1997), politicians have much control of any society. Some may view policies as a supportive measure for the promotion of adolescents' sexual and reproductive health. This may be seen from the point that policies provide guidelines and standards in meeting people's needs. Others may have a different opinion though, that policies may complicate the promotion of health or argue that by having a sexual health policy predisposes to sexual activity (Clark, 2001).

In general, governments are concerned with fertility rates, reproduction, marriage and family. As family is the foundation of any society and since sexuality and sexual behaviour have direct consequences on it, then nations can benefit from policies that promote sexual health. Moreover, if parents have the responsibility to raise their children as to become productive citizens, this is also a political success. It is interesting that many societies and cultures have regulations related to sex or sexuality such as births outside wedlock (Schwartz and Rutter, 1998). Control of sexuality is influenced by culture as well. In 1996 an 11-year-old Egyptian girl bled to

death following genital mutilation, performed by a barber. Female genital mutilation is a widely used cutlural practice associated with control of sexuality (see chapter 2). Egypt's Health Minister, Ismail Sallam, forbade doctors and nurses in state hospitals to practice this custom (IPPF, 1996a). This tactic or politic is questionable for its effectiveness. In some Arab and African Islamic countries have a policy known as purdah, meaning to keep women in isolation from men. Sometimes sexual control becomes an obsessive situation and may use the authority of religion (Schwartz and Rutter, 1998).

The current President of the United States of America, George Bush, on his second day in office, issued an executive order to reinstate the 'Mexico City Policy' or 'Global Gag Rule', a policy that was introduced by President Reagan in 1984 and withdrawn by President Clinton in 1993. This policy denies U.S.A. development funds to any non-governmental organization outside U.S.A. that uses its own funds for any abortion-related activity, including the provision of information or advocating for legal changes to fight unsafe abortion. Consequently, organizations outside U.S. are deprived of the principle of free speech related to abortion issues. The result has not been the reduction in the number of abortions, but a worsening of the quality of life and health of women, especially in the developing world (IPPF, 2001b). The American President ignores the right to Health Care and Health Protection, Article No. 9.2 of the IPPF Charter on Sexual and Reproductive Health Rights: "All persons have the right to comprehensive health services, including accessibility in all methods for fertility, including safe abortion and diagnosis and treatment for sterility and STI's, including HIV/AIDS" (IPPF, 1996b: 21). This goes beyond the pro-life/pro-choice argument. Furthermore, the President's policy comes in contrast to the American commitments of the International Conference on Population and Development in Cairo in 1994 and the 4th World Conference on Women in Beijing in 1995, which advised organizations to deal with the health impact of unsafe abortion (IPPF, 2001b).

Arguably, such political actions increase one's popularity among interested groups; especially at certain times when other socio-political conflicts exist and/or changes are taking place at national or international level and thus can turn attention to other sensitive issues. Also a subject may be popular with the interest of particular group/s; in this case the President's actions were made in response to a number of religious groups, which have enormous power within American culture or society. Arguably, it is all about control; politicians want the control because through that they gain power.

Few years earlier, when President Clinton's Surgeon General, Joycelyn Elders, noted that schools might teach teenagers about masturbation to help them delay sexual involvement, the public uproar was so virulent that she was forced to resign. Sex with no emotional connection or procreative intent is still apparently frowned on in the United States society (Schwartz and Rutter, 1998). In such a liberal society, one may argue that political intentions were behind that reaction. Probably, she was forced to resign due to the socio-political 'stigma'.

On the other hand, in America today (as in many other countries) there are so many pornographic films, books and shops with an easy access for adolescents, that obviously do not seem to bother politicians or even if they do, nothing is done about it. From a business point of view, pornographic material is a valuable economic source. Sex is seen as business and nothing more. Some American political parties and politicians are opposed to sexuality education or are more conservative in making changes in existing sexuality progammes (Lindley's et al., 1998). Of course there is no obvious immediate economic advantage to it.

Recently, an article in the Journal of the American Medical Association (JAMA, 1999, Vol. 281: 275-277), sparked major political controversy. In the article the authors explored the question "what does it mean to 'have sex'?". The publication of it led to the journal's editor being fired (Bradley-Springer, 1999). The paradox is that it took eight years (as research was carried out in

1991) to get this article published. Whatever the reason might be, it is probably the timing of this publication that caused this political controversy. It was published at the beginning of President Clinton's trial. The sample included university students (18-25 years old), predominantly White, heterosexual and self-identified as politically moderate to conservative. The facts speak alone. Even in the most democratic societies, ideologies and beliefs on sensitive matters can be controlled by the socio-political construct at a particular time, while innovations or change are not encouraged. Socio-cultural infrastructure including religious beliefs, have a dynamic impact on shaping political life.

During the crisis in Kosovo, IPPF made efforts to provide assistance to women who had been systematically raped, by sending among other health products emergency contraception. The Vatican condemned this action and stated that women should bear their rapists' children (IPPF, 2000). Furthermore, the Vatican has opposed the inclusion of education about the provision of condoms to those at risk. Such a position can put people at risk in becoming infected with an STI or HIV/AIDS. The church and state may be considered as primary control forces within a society. Nevertheless, politicians can and do challenge the state and/or the church.

Victims of sexual violence (e.g. genital mutilation, rape, murder of females), especially in Arab countries as to control sexuality are further victimized by the legal systems and by cultural reactions to victimization (Shalhoub-Kevorkian, 1998). For example, in Arab societies (including Palestine) disclosure of rape has serious consequences on female's physical, psychosocial state of mind and safety. However, uncovering victimization should be beneficial in providing help to the victim and also in planning new intervention and policies, sadly this is not the case for some of the women (Shalhoub-Kevorkian, 1999). Methods of social control, such as shame, social reputation, virginity and honor are very much emphasized within these

cultures. Females that do not respect or adhere to legal or cultural codes violate the 'honor of the family' and this gives the 'right' to the males to even kill a woman in order to restore 'honor' (Shalhoub-Kevorkian, 1999). Therefore, different methods are employed by society to 'safeguard' females, such as early and/or arranged marriage and polygamy (Shalhoub-Kevorkian, 1999). Arguably, such strategies oppress and control women, often exposing them to sexual health problems.

Sexuality is of great importance politically, particularly as it connects with family structure and the perceived stability of the state (Horrocks, 1997). Each family has its own sexuality. Within the family sexual roles are influenced by culture as well as personality. Reproductive patterns, monogamy, same sex families have an impact in society and political system too. Slap et al. (2003) in their study among students (12-21 years old) in Nigeria reported that family structure is associated with sexual activity among adolescents: Sexual activity is more common among adolescents from polygamous families. Thus, politics-family relation can be viewed in two ways; not only family structure or behaviour influence politics, including legislation, but also politics may reinforce or disempower family structure. Much of the sexual satisfaction, dissatisfaction, abuse, rape happen within the family (Kelly and Byrne, 1992).

Affiliation with certain political party is likely to influence beliefs and behaviour related to sexuality. During the eighties, political parties in the United Kingdom used sex and sexuality as major issues of political campaigns. For example, the right-wing party was against abortion, supported restriction of homosexuality and was against in-vitro fertilization and sex education in schools (Marshall, 1986). Political ideology seems to have some impact on whether one supports sexuality education or not. In Lindley's et al. (1998), study in the U.S.A., Democrat respondents were 5.5 times more likely to

support sexuality education than Republicans or Independents. Democrats seem to be more liberal in religious and political beliefs.

Politics is not a simple reflection of changes in society. However, the political context in which decisions are made, maybe important in promoting shifts on understanding sexuality and sexual behaviour (Weeks, 1989). Since church and state may have an impact on politics they can affect morality as well as gender roles. This can be vice versa too.

Education Policy on Sexuality

Recently, scholars in many developed countries have contended that the policy-making process in education has been more and more politicized. New definitions of school purposes have given rise to a web-like set of political relationships surrounding the local school (Rienzo et al., 1996). The political drive to improve health is usually expressed in terms of goals and indices that will measure improvement outcomes. Schools seem to be the means to implement sexuality education, thus improvements will be achieved (Hendry et al., 1995). This is challenging since it provides the opportunity to try new ideas and evaluate programmes. The school seems to be the most appropriate place to do this. The school provides knowledge, knowledge gives power and power is an important asset for the formation of policies, political decisions and control. Since it is hoped that young people are enthusiastic and open to change, they may also be in good position to critique new systems.

It can be argued that promoting safe sexual practices for everyone, regardless sexual orientation and lifestyle, should be a basic principle of school health promoting programmes (NIGZ, 1996). To avoid unwanted effects, clear objectives, monitoring the process and measuring the outcomes should be emphasized in school sexuality education (Mellanby et al, 2001). This leads to the necessity of a school policy. The National Healthy School

Standard in U.K., provided guidance criteria for a school policy. According to Sex Education Forum (2000:2-3) a policy should:

- Be owned and implemented by all members of school and parents
- Match the needs of students' age, ability, gender and level of maturity
- Be based on students' own assessment of their needs and knowledge of vulnerable students
- Provide students with support services in partnerships with local health and support services
- Be responsive to natural priorities

Recent American studies showed that most States require elementary schools (80.4%), middle/ junior high schools (80.4%) and senior high schools (80.4%) to teach some health education. More than 50% require school to teach sexuality issues (e.g. HIV, STI's), (Kann et al., 2001). However, 78%-80% of districts require schools to notify parents/guardians before providing instruction on human sexuality (Kann et al., 2001).

One may view the whole idea of sexuality education in two extremes: The impulse toward restrictive orthodoxy and the impulse toward expansive liberalism (Levesque, 2000). The restrictive ideology views human sexuality negatively and sexual behaviour on the bases of legal, social and moral controls. The idea focuses on abstinence (see section 4.4) as this idea is gaining popularity with the resurgence of abstinence-based U.S.A. national legislation (Richards and Daley, 1994). Thus, they argue that there is no need of comprehensive sexuality education and no school policy is necessary. The permissive ideology views sexual behaviour as a pleasurable aspect of life. This approach is characterized sex as positive, pluralistic and comprehensive (Levesque, 2000). Therefore, they support sexuality education and policy in school. However, either idea will not probably be beneficial if follows extreme tactics.

It can be argued that coherence between health education, care and school environment can be guaranteed by a school policy on sexual health (NIGZ, 1996). This may offer social and political support for teachers in applying education on sensitive issues (NIGZ, 1996).

Rienzo et al., (1996) in their study examined the content of school district programmes (U.S.A.) related to sexual orientation and the social and political determinants of these school programmes. Their findings reveal that most of the school districts are not providing many of the sexual orientation programme components such as sexual orientation education to parents, community and staff. Rienzo et al. study (1996), affirms that political forces are significant influences in education programmes and policy. Therefore, an existing supportive system for education/school policy will possibly have more success in its development and implementation.

In some countries the sexuality education is optional, so permission is needed from parents as to attend such a class. In other countries it is an extra-curricular activity. Literature reveals that with constructive exchange of ideas and scientific support interested parties can come to a reasonable, acceptable agreement (Levesque, 2000 ; Rienzo et al., 1996).

Any school policy on sexuality education should incorporate positive conceptions of mental, physical and social health (Hendry et al., 1995) while taking culture into consideration. A harmonious blending of policy and education will not only give positive messages to anyone affected by it, but it will reinforce school's attempt in promoting health. Nevertheless, different theoretical approaches on learning about sexuality must be reviewed as to find the most appropriate for each community, society or culture.

4.3 Theoretical Approaches on Learning about Sexuality

Several American sex education programmes associated with changes in sexual behaviour have used methodologies derived from **Bandura's (1977) Social Learning Theory** (Mellanby et al., 1995). According to Bandura's social-cognitive learning theory, human behaviour is formed mainly through modeling. Throughout their development adolescents are exposed to a variety of behavioural patterns. They learn partly by observing the behaviour of others and the rewards and punishments that the behaviour of others elicits. Through observation children learn the consequences of various behaviours without having to experience them. The social-cognitive learning theory highlights that only certain persons or behaviours can be imitated. For example, people who are considered attractive or with high social position or power are more likely to be imitated (Kleiber and Pforr, 1994). There is evidence that applying principles of social learning theory in health education, rather than more traditional educational methods of didactic teaching, is more likely to cause behavioural changes (Mellanby et al., 1995). Curricula such as Postponing Sexual Involvement (see section 4.4) that were based on social learning theory provided evidence for behavioural change (Kirby, 1992). Bandura's social learning theory supports that an action, such as using contraception, is determined by a) the understanding of what must be done to avoid pregnancy b) the youth's belief that will be able to use the method c) the belief for the success of the method and d) the anticipated benefit for this behaviour (Kirby, 1992). Critics of this theory argue that children/adolescents are not so passive as social learning theory assumes (Myers, 1989). Adolescents develop the necessary skills required for certain behaviour through practice (Kirby, 1992). Therefore, people's behaviour is best understood according to one's own perceptions of his/her environment (Evans et al., 1998). Nowadays, organizations that are involved in sexuality education or sexuality in general, such as FPA, RFSU (Swedish Association for Sexuality Education), promote learning through experiential methods such

as role-playing may be a useful methodological approach within sexuality curriculum in applying this theory.

The **Health Action Model (HAM)** (Tones, 1995), examines the interaction of cognitive factors (knowledge, skills, beliefs), motivating factors (values, attitudes, drives) and the influence of the social norms of the community one lives in. All the above are associated with behavioural intention (Hendry et al., 1995). The health action model is a comprehensive framework that includes factors that influence health choices and actions. Health action model emphasizes the ways in which skills and competences contribute to empowerment (Tones, 1995). It places individuals in control of their environment. However, when individuals may fail to control certain circumstances, the health action model highlights the development of healthy public policy (Tones, 1995). The beliefs about control are based on the construction of self (e.g. self-esteem), including beliefs about the self (Tones and Tilford, 1994). Knowledge alone is inadequate and skills are essential in decision-making. Values and attitudes may determine whether or not an individual will promote change. A competent adolescent should reflect in different life situations and understand him/her self in relation to social context and settings in order to take the responsibility of decision-making and action (Hendry et al., 1995). The aim is that health behaviour may become a routine as it is reinforced by the socio-economic and cultural environments. Thus, this approach might be beneficial for sexuality programmmes, based on the idea that socio-cultural factors have a strong impact on sexual health behaviour. However, understanding the dynamics of health related decision-making is a step in succeeding promotion of health. According to Hendry et al. (1995), the health action model explores the process of making healthy choices in more detail as compare to other models.

McLeroy et al. (1993), suggested that **Ecological Planning Approach** offers an appropriate use of theory in health education. This requires:

-Developing an understanding of the psycho-social factors affecting the problem and the inter-relationships, among factors at different levels of analysis;

-Knowledge of previous interventions and their effectiveness with various cultural groups;

-Awareness of the context (organizational, community, cultural) within which programmes will function.

This approach highlights the importance of synthesizing what is known across levels of analysis. This implies how organizational factors affect social networks or the relationships among community, organizational and network characteristics and how they interactively affect the individual's behaviour.

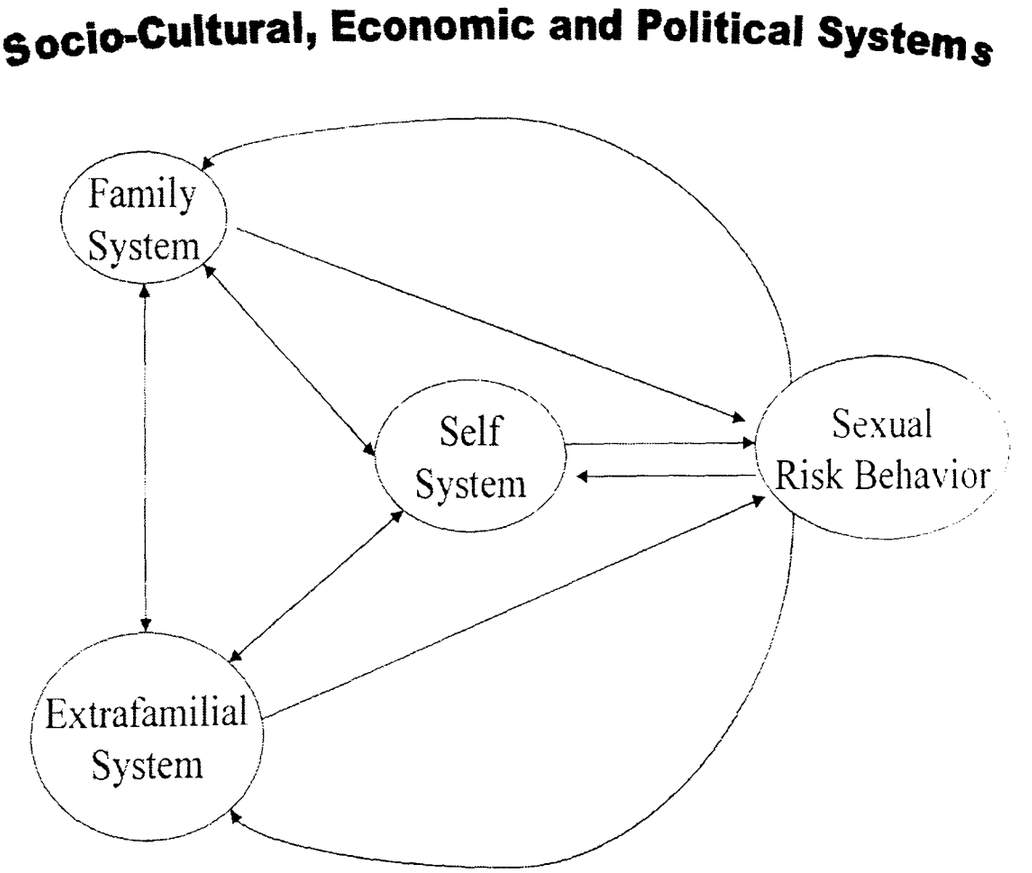
The emphasis is not strictly the educational and psychological interventions. It is assumed that if students can develop a theory of the problem about one health issue, they can apply it to other health problems too (McLeroy et al., 1993). A theory though may change or may not be applicable under the same or different circumstances, in the same or in a different problem. Therefore, developing a theory alone is insufficient; skills to put the theory into practice are probably what needed most.

Kotchick et al., (2001), examined adolescent sexual risk behaviour from a multisystemic perspective (Figure No.4.3.1). This approach was based on ecological systems theory, which emphasizes the reciprocal relations among multiple systems of influence on a person's behaviour. Therefore, a comprehensive and accurate account of sexual behaviour must include some knowledge of personal and environmental factors. These may influence one's decision, for example to become sexually active. Particular attention is given on the self, family and extra-familial systems, as they may contribute to adolescents' sexual behaviour.

Although the health action model has some similarities with the ecological planning approach, the ecological approach explores more the socio-cultural norms of a community/culture. According to Bronfenbrenner (as cited by Kotchick et al., 2001), macro-level systems permeate through micro-level systems, meaning that cultural or economic systems influence the self and the extrafamilial system and consequently these have a direct or indirect impact on one's beliefs and behaviour. Thus, the ecological approach seems to be more preferable because of this. However, even more emphasis can be given in the power of socio-cultural system on one's beliefs and behaviour.

Despite their differences, all these theories appear to support the position that the development and implementation of effective sexuality health programmes requires awareness of the norms and values of the particular culture. A variety of programmes have been developed for the promotion of sexual health. Some of the programmes are based on these theories (see section 4.4).

Figure No.4.3.1: A multi-systemic perspective on adolescence sexual risk behaviour (Kotchick et al., 2001:496)



4.4 Education for Sexuality

Sexuality education is currently one of the most controversial and politicized aspects of the school curriculum (Measor et al., 2000). It is necessary at this point to distinguish between sex education and sexuality education. Sexuality education "...covers the concept of total well-being, health promotion and a socio-ecological perspective. It includes sexual development, personal and interpersonal skills, relationships and social and cultural influences", while sex education "...refers only to the physical dimensions of sexuality education" (Clark, 2001:28). Therefore, sexuality education covers a much broader perspective.

Sexuality is part of one's own identity. Thus, it may influence one's personal identity or may be influenced by it, in the formation and expression of sexuality. Based on these ideas, some argue that sexuality education helps adolescents to understand the basic need of belonging, to love and to be loved. At the same time, the person learns about his/her own rights and duties and to respect his/her own self and others (Creatsas, 1998). However, this also depends on values and beliefs within the family and within a particular culture. Human beings are sexual from birth to death, thus it can be argued that an adolescent that does not engage in sexual intercourse is still a sexual being since sexuality is far more than having sex. Based on this concept the young and the very young can be considered as priority groups in sexuality education. Different researchers argued that education is preferable to take place prior to the onset of the behaviour (Oakley, 1994 ; Haddad, 1993); and thus adolescence is almost too late for sexuality education (Haddad, 1993). The Family Planning Association goes even further to say that there is no age at which a person is too young to begin to learn about sex and relationships. Formal sex and relationships education should begin at nursery school (FPA, 2000). According to Sinanidou (1997) sex education is always late, since it can not be taught the same way as one is taught how to

read. This probably means that sex education needs more active and experiential learning than maybe other topics (e.g. language).

According to Ioannidi-Kapolou (2000), Greek young people, especially secondary school students are not well informed about sex-related issues such as STI's, HIV/AIDS and contraception. Therefore, they usually begin their sexual life without adequate information on these subjects. This exposes them and others to unnecessary danger. It has been reported that most Russian adolescent students have only one to two hours sexuality education in school, which is far too little to deal with all issues needed in a satisfactory manner, thus most of their questions remain unanswered (Kettting et al., 2001). In Romania where adolescents received sexuality education, most of it was theoretical and did not deal with issues relating to safe and risky sexual behaviour (Jejeebhoy, 1999). In a study in Lebanon high school students reported the need for education on sex-related issues, especially STI's (El-Kak et al., 2001). This adds to the evidence, which suggests that sexuality education needs to go beyond anatomy and physiology and focus more on psychosocial and cultural issues. This requires the support of the state as well as school policies and educators who believe in its importance. It should also address positive and negative aspects of human sexuality, including abstinence, abortion, masturbation and homosexuality. According to Sathe (1994) the findings of an evaluation of a sex education programme applied in Indian adolescents reveal that the majority of the participants felt that the programme helped them to relieve their apprehensions about growing up such as body image and/or night dreams. Although some health education programmes (e.g. smoking) suggested that knowledge is irrelevant to teenager behaviour, some studies found that the level of adolescents' understanding of human sexuality limited their ability to make informed decisions (Mellanby et al., 1995).

In contrast to the evidence, which supports sexuality education in schools as a useful and necessary component of the young people's education, some

researchers are more skeptical about sexuality education and its effectiveness. For example Pleck et al. (1993), reported that there was no significant increase of proper use of condoms following sexuality education. Even though education seems to increase knowledge on sexual matters (Plotnick, 1993 ; Kirby, 1992), it fails to have statistically significant increase or decrease in sexual activity. Therefore, it has no measurable impact on sexual behaviour (Levesque, 2000). Wight et al. (2002) reported that only few randomized trials showed that sex education can reduce sexual risk taking by young people. Adding to this, an evaluation of seven short-term sexuality education programmes were found to have had no effect in delaying first sexual intercourse or increase effective contraceptive use (Eisen et al., 1990). Arguably, research evaluation of such programmes should reveal the reasons of failure, because it is on evidence-based research that one must based revised sexuality programmes or decide alternative ways for promoting sexual health. There is a variety of aetiological factors that may contribute to the ineffectiveness of sexuality education: The programme itself, the content, its cultural specificity and sensitivity and the way in which it addresses the needs of a particular group. There is no universal recipe for it. The professional that delivers a specific programme or the age of the participants may also influence the successful or otherwise delivery of a programme. According to Wight et al. (2002), improvements in teacher delivered whole class sex education have some beneficial effect on the quality of young people's sexual relationships but they do not influence sexual behaviour.

However, based on the previous discussion, failure of achieving the desired results is not an argument for abandoning sexuality education but an argument for improving its delivery.

Nevertheless, some argue that abstinence-only education should exist, since instruction on such topics violates parental authority and promote premarital sexual relationships (Lindley et al., 1998). According to Plotnick (1993), even though abstinence may have an impact on virgins, they have little effect on adolescents who are already sexually active. Furthermore, abstinence

programmes need to include contraceptive information and referral (Plotnick, 1993). Individuals that oppose sexuality education seem to strongly believe that young people need to be taught from childhood moral absolutes of right and wrong, as to return to the 'traditional' family values. Strong religious and personal beliefs are the usual reasons for individuals opposed to sexuality education. It is unlikely that one will drastically change his/her mind during an educational campaign for sexuality issues. Definitely, religion influences should not be ignored. Whatever religion is held it plays an important role in shaping one's own values, attitudes and behaviour within everyday culture. Values and beliefs are strong assets for one's own lifestyle. For example, based on Biblical principles of Christianity sexual relations should not occur outside marriage (Lindley et al., 1998). The Vatican, as previously mentioned in this chapter, has opposed the inclusion of sexuality education about and the provision of condoms even to those at risk (IPPF, 2000). Arguably, such extreme actions may influence church attendance. Church and religious leaders views are very much respected even if their congregations disagree with some of the leaders' views. The intention is not to give more emphasis to church/religious ideas compared to other groups with strong positions regarding sexuality education (e.g. parents, homosexuals). Therefore, the views of the religious leaders can not be overlooked, when developing sexuality programmes. This does not imply necessarily that an abstinence-only programme or no sexuality education will be introduced. It may mean that such programmes would avoid or minimize friction and may result in culturally appropriate and religiously acceptable programmes of sexuality education.

Several factors affect not only early sexual initiation (NHS Center for Reviews and Dissemination, 1997) but attitudes and behaviour of sexuality in general (Table No.4.4.1). Factors such as family, society, economy and education are components of culture. An analysis of the following table highlights how culture influences attitudes and beliefs regarding sexuality. For example,

young females with good general education are more likely to defer pregnancy. Another example could be that high risk groups for teenage pregnancy includes daughters of teenage mothers (NHS Center for Reviews and Dissemination, 1997). Therefore, it can be said that family and education are associated with adolescent sexuality. Furthermore, one may argue that the table emphasizes the triage self, family and extrafamilial/environmental factors, a similar concept to the ecological approach that was discussed in the previous section (4.3). Meaning that an adolescent should be viewed, understood and approached in relationship with his/her environment such as family, education, community etc.

Table No.4.4.1: Factors associated with early sexual initiation, contraceptive use and teenage pregnancy (NHS Center for Reviews and Dissemination, 1997:3)

Individual	**Family**	**Educational**	**Community**	**Socio-economic**	**Contraceptive**
Knowledge Self-esteem Skills base Cognitive maturity 'Experimental' behaviour Age of first intercourse Emotional maturity	Parent-child communication Mother or sister teenage pregnancy history Family structure (including single headed families)	Academic attainment/ educational goals Truancy Sex education	Social norms (sexual activity/ pregnancy) Peer Influences Cultural and religious influences Media influences Child abuse	Poverty Employment prospects Housing and social conditions	Contraceptive services Awareness Availability Accessibility

The Ottawa Charter for Health Promotion suggested a framework that may assist in sexuality education programme development (Thomas, 1996:93):

a) As teens have trouble articulating their needs, due to discomfort with language and embarrassment, they should be *enabled* to discuss sex through an exploration of acceptable terminology to ensure mutual understanding between themselves and the educational facilitator.

b) Interpersonal *skills* such as effective communication, decision-making and relationship building should be developed in adolescents so they are better able to deal with partners in a sexual relationship.

c) Appropriate physical and psychological *environments* in which teens are free to openly discuss their needs and concerns, without fear of confidentiality being breached, are vital.

d) Adolescents who require contraceptive advice and provision should be referred to *health services,* which should be user friendly and non-threatening to this group.

e) *The policy on promoting health*, including sexual health, in schools should permeate all areas of the school curriculum and not be relegated to the science and religious education portions of the syllabus.

According to Haddad (1993) even if there is no regular sexuality education course in a school, special activities are preferable to be organized such as conferences, exhibitions, young people's journals to give the opportunity to adolescents to discuss topics they are interested in. Arguably, an organized sexuality education programme will probably be more beneficial, instead of spontaneous activities, because education can be built gradually according to the age and needs of the student.

But irrespective of legislation, religious objections or school policies adolescents get information or misinformation anyway, from peers, mass media, magazines, internet and books. Lebanese secondary school students

also reported as the major source of information on sexuality their friends and the mass media (El-Kak et al., 2001), just as their British counterpart reported (FPA, 1997b). This is a universal phenomenon. However, misinformation strengthens the myths and misconceptions about sexuality (Sathe, 1994). A survey of 18,876 young people and adults in Britain, found that those who reported learning about sex from school lessons, were less likely to have had sexual intercourse before the age of 16, than those whose main source had been friends or the media (Wellings et al., 1995).

Adolescents under peer pressure may experiment in sex-related activities. These experiences may have an impact, not only on their immediate behaviour (e.g. take advantage of a girlfriend/boyfriend), but even during adulthood. Sometimes, they get trapped in difficult situations because of their ignorance (Sathe, 1994) and this may cause traumatic experiences. According to Wellings et al. (1995), early (although the precise meaning of 'early' is not given) experience of sexual intercourse is more likely to cause feelings of regret, larger numbers of sexual partners and unplanned pregnancies. Nevertheless, some may have good early experience of sexual intercourse and useful information from the mass media.

Young people need to be prepared as to manage the emotional and biological challenges within relationships with competence. This is not so easy in the contemporary world where young people are bombarded with a variety of messages and are having so many challenges (e.g. media). Health promoters and health professionals can create a positive dynamic to combat sexual illiteracy.

Even though sexuality education is slowly becoming a more normal school subject in some European countries, in others (e.g. Greece, Cyprus) is still a major issue of discussion, as to whether and it will be introduced in schools. Living aside attitudinal factors, one could argue that the reasons for this, is not only that these countries may lack skilled teachers/educators but they

may also lack adequate materials to use. Even school facilities and rules can be very influential on sexuality attitudes and behaviour. For example, dirty and ill-equipped toilets have implications for how young girls learn to respect themselves (Sex Education Forum, 2000). Most of the Russian girls reported that they prefer doctors or family planning officers for sexuality education, whereas most of the boys reported the school psychologists as a first choice. It is interesting to note that in this same study their preferred source of information (but not getting from) was the schoolteacher or some other unidentified source (Ketting et al., 2001). This may be a person that visits or is at the school very often (e.g. school nurse). The sensitivity or lack of it as shown by teachers on such matters, forms part of the whole school ethos on sexuality education. Since sexuality issues such as menstruation, premenstrual syndrome and sexual activity impacts on the students' academic performance it becomes imperative for schools to seriously address them (Sex Education Forum, 2000 ; Walker et al., 1998). The importance of the adults' knowledge and ability to deal with numerous issues related to sexuality was stressed by Creatsas (1998) who suggested that sexuality education should start from the adults, since many Greek parents reported that they feel the need for this.

Whilst sexuality education provided in schools is crucial, research also strongly suggest that the role of the family is also very important. Research has shown that parental communication about sex is related to decreased sexual risk behaviour among adolescents (Kotchick et al., 2001). Consequently, it is easier if communication begins early and is unsustained, than to attempt in establishing during adolescence, since so many changes are occurring at that time (Haddad, 1993). It seems that parents considered by young people to be one of the best resources for sexuality education (ketting et al, 2001). Arguably, not all can do it either due to knowledge, beliefs and/or communication skills. According to Ketting et al., (2001), in Russia adolescents believe there is a gap between their own and their

parents' knowledge and attitudes towards sexual relationships. Almost half of adolescents think that their parents' attitudes are very conservative and only one third of the respondents can talk with their parents about sexual relationships, despite that one of the most preferred resource is their mothers. Creatsas (1998) stated that most parents feel they should be talking to their children about sex. The problem is that they are just too embarrassed to discuss these issues or they do not know how much to tell them or they do not have the knowledge to do so. Adolescents as children receive their first messages from their family. School will build on these experiences and knowledge. Greek parents stated their need to become more sensitive and knowledgeable on this matter as to be able to help their children.

Returning to the importance of complementing home-based sexuality education with a school-based one, Creatsas (1998) reported that individuals who teach sexuality education should have the ability to build a trusting relationship with young people, to be friendly, knowledgeable, to have teaching skills and feel comfortable to answer in specific and sensitive subjects such as masturbation, homosexuality, abortion, contraception, drugs and so on.

Bradley-Springer (1999:16), strongly argued that "...the HIV epidemic is nothing if not a result of our inability to discuss difficult issues such as ...sex, violence, gender discrimination to name a few". Taboo and 'common secrets' do have consequences. According to Sex Education Forum (1997:5), male students identified the following characteristics for a good sex educator:

- knows his/ her stuff
- does not get embarrassed
- has some sense of humor- he/she makes it fun
- does not ridicule or embarrass students

- is able to control the class
- is either male or female, but with some male input for certain aspects of sex education

Arguably, since gender differences exist at some point (see chapter 3) if girls were asked these characteristics would most probably not be exactly the same. It is questionable if they would have mentioned the last one -about the 'male input'- which is not clarified what exactly adolescents' thoughts were entailed. In Indian society attitudes towards sex are predominantly male-oriented. A woman is looked upon as a sex object (Sathe, 1994). Russian girls tend to get more information at school on sexual relations than boys, since most of the programmes are aimed at girls (Ketting et al., 2001). However, research has shown that girls' sexuality education is mostly 'reproductive' in protective terms: "Do not let him do this or you will get pregnant" (Sex Education Forum, 2000:2). Any gender should be studied beyond reproductive issues. Not that they are less important but are equally important as the psychosocial, economical and political aspects of adolescent sexuality education. As mentioned in previous chapters culture and gender as well as religion are factors that are inseparable to health and education. It has an impact on understanding and expressing sexuality.

Training of teachers is a necessity. Douglas et al. (1997), reported that where teachers lacked experience and training, they avoided the issue of homosexuality or slightly touch on it within the context of HIV/AIDS. Avoiding sensitive or controversial issues is not constructive for sexuality education. Appropriate teacher training would result in more effective sexuality education where the teacher can no longer be seen as the only expert. Both the Health Action Model and the Ecological Planning Approach, that were discussed earlier, viewed the teachers/educators as facilitators and group guides who promote active learning and avoid lecturing or preaching. Teachers do not

'actually teach' but rather they facilitate learning and offer stimuli to students for self-learning. In recent years this approach is promoted in education in general (Schon, 1987). Facilitation also means guidance to independent searching of knowledge and correcting the student where needed as well as challenging the students.

Therefore, pedagogical skills, as well as group dynamics skills and generally personal skills (e.g. openness, flexibility) need to be developed by teachers thus, involving students in their teaching methodologies for the maximum effect (NIGZ, 1996). Reluctance among parents and ambivalence among educators and sex education programmes about the provision of the relevant information, compound adolescent ignorance about sexual and reproductive health (Jejeebhoy, 1999). A good professional sexuality health educator is the one who has worked these issues within one's self first.

Adding to these, Creatsas (1998) supports a multi-professional team for sexuality education. This includes adolescence-psychologists, sociologists, midwives, doctors and social workers. Having such a team, is not so easy. However, other professionals may be included in this team such as priests, school teachers/educators and nurses. Usually one of these professionals that is trained for sexuality education covers the subject whilst the others offer advice and support. For economical reasons, only a few schools are able to provide a multi-professional team for sexuality education. Furthermore, some decision-makers may avoid the involvement of different disciplines on purpose, in order to gain the credit of possible success. However, due to the complexity, diversity and challenge-orientated nature of sexuality issue, the input of a multidisciplinary team may be more appropriate.

Children learn from the formal and the 'hidden' curriculum what is considered to be appropriate behaviour for each gender. The hidden curriculum is not generally acknowledged by school officials but may have more impact on students than the official curriculum. The school is an institution and thus it embodies a set of norms and values. 'Hidden' curriculum is somehow a

media that transmits or underlines values, beliefs and attitudes and this is essential since it can directly or indirectly, positively or negatively affect students' behaviour. Above mention was given to the influence of school facilities such as toilets and the teachers' sensitivity towards the female students' menstrual and pre-menstrual issues. According to Posner (1995) the messages of hidden curriculum are often related to gender, sex roles and 'appropriate' behaviour of young people, for example, whether boys should express emotions or not or whether homosexuality is a normal behaviour or not. Sexuality school curricula may be covertly biased towards one or the other gender. Generally, it is essential that gender specific sexual health-related issues to be stressed, giving equal importance of gender roles in a relationship as well as in health-related matters such as male or female multiple partners.

In school, fragmented and ad hoc information from mass media, peers and adults, can be placed in a formal comprehensive framework (NIGZ, 1996). According to Kirby (1995), school is the institution that young people regularly attend, is geared towards increasing students' knowledge and improving their skills and is especially well fitted to educate young people on issues such as sexuality, where different concepts should be taught at different developmental stages. Conditions in school may not be ideal, but is one place that young people gather to acquire knowledge. Thus, it can provide a coherent approach often lacking by organizations concerned with family planning and contraceptives, the prevention of AIDS/ STI's and the healthy life style of adolescents, which invariably work separately. In order to guarantee a long-term perspective for sexuality education in schools, it should be structurally embedded in the policy of institutions related to sexuality and youth (e.g. schools, preventive care, educational policy makers etc.) (NIGZ, 1996).

Homosexuality is often seen an antithesis to normative heterosexual desire (Bristow, 1997). The general perceptions of any health educator/promoter as well as school policies, 'hidden' and/or formal curriculum regarding homosexuality, have an impact on the people they serve especially young people. The important point in all of the above is that biased, uninformed or misinformed teachers directly influence young people's attitudes and beliefs. Arguably, young people need clear messages with correct information/ knowledge. Telljohann et al. study (1995), presented interesting results regarding teaching and the beliefs related to adolescent homosexuality of high school health educators. Fifty secondary (high) schools were randomly selected from each of eight selected states of America. Thus, four hundred schools were identified, from which one health educator was mailed the survey (n=211). Appendix No.1 shows the perceptions of high school health teachers about homosexuality, by assessing their beliefs in sixteen items. These teachers seem to be unclear about some stereotypes related to sexuality. For example, 16% of the respondents disagreed that male homosexual students are more likely than most male students to be interested in the creative and performing professions. In addition, 37% disagreed that female homosexual students are more likely than most female students to participate in athletics. It is interesting that in the same study, it was reported that most of their information on this matter was from the mass media. Arguably, this may not be the best source especially for a health educator. Also, 35% of the respondents agreed that schools are not doing enough to help homosexual adolescents adjust in their school environment.

Furthermore, in the same study of Telljohann et al. (1995) it was argued that adolescent homosexuals are engaging in unhealthy behaviours due to social and emotional isolation. They have eight times higher rate for cocaine/crack use, 50% higher rate for alcohol use compared to the total adolescent population. Less than one in five homosexual students can identify someone, who had been very supportive to them. In most sexuality related resources lesbians are invisible. As Sex Education Forum (2000), argued this may have

serious impact on one's self-esteem. Nevertheless, there is much written material related to homosexuality. Students suggested that schools could be more helpful if homosexuality is taught in a positive way (Telljohann et al., 1995). It could be argued, that 'positive way' may be promoting homosexuality. However, it may be just stating the facts. Whatever it may mean should be clarified within a curriculum context. The Family Planning Association (2000), believes that all people should be valued equally, despite their sexual orientation.

Each unique person within one's own culture views differently sexuality-related matters such as homosexuality. For some it may be immoral (Green and Tones, in Wilson and McAndrew, 2000), for others it may be just a different sexual orientation. Promotion of homosexuality is not a part of any health education, but respect of sexual diversity is a need. In the U.S.A. schools making stronger efforts to deal with sex orientation issues, are usually found in States that adopted gay rights, laws or policies (Rienzo et al., 1996). It is interesting to note that in South Africa, it was not until 1988 that age limit for sexual relations between girls and boys has been raised from 7 to 16 and the one for lesbians from 12 to 19 (Graupner, 2000), wondering if there is more appropriate/healthy or legal of a 7-year old heterosexual act than a 12-year homosexual act. Arguably, either behaviour is not to be encouraged or accepted when underage. The issue though is much deeper. Traditionally, girls have been seen as more vulnerable compared to boys. Based on this it is understandable why several countries such as Cyprus have different age limits for girls and boys (Graupner, 2000). Furthermore, the Treaty of the European Community empowers the Community to enact measures against discrimination on the basis of 'sexual orientation'. Therefore, the European Parliament declared that it will not allow the accession of countries to the European Union whose legislation discriminate against lesbians and gay men (European Parliament, 1998 and 2000).

Sex Education Forum (1992:1) suggested that sex education should:

- Be an integral part of learning process, beginning in childhood and continuing into adult life
- Be for all children, young people and adults including those with physical, learning and emotional difficulties
- Encourage exploration of values and moral issues, consideration of sexuality and personal relationships and the development of communication and decision-making skills
- Foster self-esteem, self-awareness, a sense of moral responsibility and the skills to avoid and resist unwanted sexual experience.

Although these guidelines take in consideration important parameters on learning about sexuality such as the self and values, still it can be argued that socio-cultural perspective is undermined; this may be said that it is an essential part of sexuality education compared to sex education.

Serious considerations in educating for sexuality are the educational tools and methods used. For example, some argued that a sexuality book is a necessary source as one could consolidate what was said in class. Questions and answers, pictures and drawings help to comprehend the subject even better (Creatsas, 1998). A supplementary source may be a video that has successfully been used in sexuality programmes. Care should be taken to ensure that resources used, do not blame individuals as it has occasionally been reported that young women are solely responsible for the failure of contraception or the consequences of unprotected sex (Sex Education Forum, 2000).

According to the Sex Education Forum (2000) researchers in the U.K. have found difficulties when bringing single gender groups back to report to a mixed gender group. A more successful approach seems to be a small mixed gender group. This enables a more honest and open exchange of opinions

and views. In some schools a single gender time is used also as some students find this approach useful. This approach may help to alleviate some of the difficulties of tailoring sexuality education to very different needs and stages of development when dealing with a full class. Both approaches can be used. Certain topics can be discussed separately according to the needs of adolescents. Arguably, this may be done only with the agreement of the adolescents involved. For example, if the topic is menstruation, girls may ask personal questions and could be embarrassed to do so if boys are present. However, it may be interesting and useful for boys to listen to the girls' experiences. Furthermore, it seems that a more fruitful and challenging interaction exist when both genders are together, but when in very small groups (4-5 people). From a practical point of view, a big class of 30 students can have some difficulties in discussing sensitive issues. Realistically, small group discussions or gendered-oriented groups are more resource intensive. Either more time should be allocated in over crowded curricula or more teachers need to be involved.

Peer education is a considerably new methodology in sexuality education. Peer education, using young people for young people in promoting health, has been a debate for many researchers and health educators. In Baltimore, U.S.A., a peer education sexuality programme was implemented, and was reinforced by after school discussions. The onset of sexual intercourse was delayed among those who had not initiated sex, and among those who had initiated sex, the use of birth control increased and pregnancy rates declined. Kirby (1992) reported that these changes may have been the result of the programme or due to chance fluctuations over time.

The advantages of interaction during peer education, have been described by Kleiber and Pforr (1994) as symmetry, equality, complementarity and mutual control. According to Youniss (as cited by Kleiber and Pforr, 1994) a deeper understanding can occur through interaction with persons of the same age.

Peers offer a social and an emotional environment where behaviour can be tried and tested without sanctions being imposed (Oerter, as cited by Kleiber and Pforr, 1994). In Mellanby et al. (2001) study, peer-educators effectiveness in establishing the 'norm' -not having sexual intercourse before sixteen years of age- was considerably stronger than that of the adult-leaders. Peer involvement seems to be a promising approach. However, more research is needed about this approach. Peers even when trained, may face difficult situations when they are unable to handle an intimidating question or behaviour. Nevertheless, this may be experienced by adult educators too.
Although many programmes that have been considered effective, used peer leaders, Kirby et al. (1994), did not consider this as an essential component. Evidence for peer-leader effectiveness is slender (Mellanby et al., 2000). There is evidence that peer educators do not impart knowledge any more successfully than adult experts. But is not only the knowledge one acquires, is the skills and abilities that will help one to be self-competent and assertive. Although this is outside the 'traditional' learning methodology, young people when they have a question seemed to approach other young people more frequently than adults (Kleiber and Pforr, 1994). This may be because they share the culture of youth. The use of peer involvement approaches with peer-leaders, in combination with health promotion approaches with adult-leaders, maybe useful in promoting sexual and reproductive health. However, more sexuality programmes do not explicitly involve or promote the involvement of peer educators (as will be seen below).

In Ogletree's et al. (1995) study, 23 sexuality education curricula were evaluated. A significant percentage (43%) underlined the philosophy of 'healthy sexuality'. Such a philosophy promotes sexuality as natural and healthy part of life. This is essential in exploring the idea of healthy behaviour as well as developing strong bases for comprehending sexuality education. Throughout the years, different sexuality education curricula were designed, emphasizing a variety of issues: Risk and consequences of pregnancy,

knowledge, values clarification and skills, especially decision making and communication skills (Kirby, 1992). The prevention of adolescent pregnancy with its physical, psychosocial and economic consequences and the prevention of STI's have become central goals for many sexuality education programmes (Eisen et al., 1990). A holistic view of sexuality in such programmes will be more beneficial for young people. Nowadays, several programmes, such as Postponing Sexual Involvement, are based on theoretical approaches. According to Wight et al. (1998), there are greater belief and behaviour changes amongst those most at risk when participating in a theory-based programme, compare to the routine sexuality education programme in schools in the Netherlands. Skills-training programmes that promote abstinence have shown mixed results. Arguably, several factors may influenced these results, such as timing of education, whether adolescents were sexually active or not, social and environmental factors.
Several examples of sexuality programmes are mentioned below:

The Program Archive on Sexuality, Health and Adolescence (PASHA), represents a possible starting point for schools, community groups, service agencies and clinics in sexuality and health education of adolescents. The PASHA programme package aims at the prevention of pregnancies and STI's, among teenagers and availability of material to professionals. PASHA is a credible resource of sexuality education programmes based on applied research from experienced researchers. Five experts in sexuality issues served on the PASHA Scientist Expert Panel reviewing prevention programmes. To increase credibility an important criterion was that a programme should have at least one evaluation-related paper or publication documented in scientifically acceptable fashion, its success in changing at least one fertility or STI related behaviour in adolescents or young adults. A scientifically acceptable included appropriate design, methodology and a follow-up assessment (Card et al., 1996). Some of the programmes selected are: Postponing Sexual Involvement, Strategies to empower youth to reduce

their risk for AIDS, Human sexuality values and choices, Health care programmme for first time adolescent mothers and their infants. PASHA is based on the principles of social learning theory, aiming to provide persuasive and powerful role models for adolescents (Card et al., 1996).

Postponing Sexual Involvement (PSI) is a sexuality education programme, aiming to support adolescents in delaying sexual activity, helping them to understand the social pressures, teaching them skills so as to be assertive, set limits and resist pressure. It could be said that the intervention (five sessions) is too modest to have significant impact on behaviour. Only the curricula that lasted approximately 15 sessions have led to changes in adolescent sexual behaviour (Kirby et al., 1997). Such programmes of postponing sexual activity have had some success in changing sexual behaviour among young people (NHS Center for Reviews and Dissemination, 1997), and maybe more effective if they focus on very practical skills (Kirby, 1992). P.S.I. curriculum gives considerable emphasis to norms, focusing on delaying intercourse. High school students as peer educators presented the programs at junior high schools. Evaluation of it provided evidence for behavioural change. Still some are more skeptical in peer-level education. This may be successful for one society or culture but not for another.

A PAUSE (Added Power And Understanding in Sex Education) is a programme of sexuality education for secondary schools. It includes 10 sessions (6 adult-led and 4 peer-led). In A PAUSE programme social learning theory is a central component. The scope is to alter three major influences on behaviour: Personal factors, Social environment and Actual behaviour. Positive effects have been reported for this programme (Mellanby et al., 2001; Mellanby et al., 1996). A theory-based curriculum that provides contraceptive information and applies skill-building activities is more effective at reducing high-risk sexual behaviours, than more traditional and abstinence–only curricula (Hubbard et al., 1998). The programme holds that it is through the

symbolic enactment and practice of such knowledge, attitudes, behaviour and intentions through the performance of desired behaviours in role-play situations, that an alternative behavioural repertoire may be acquired (Evans et al., 1998). It seems that empowerment of young people for healthier and less risky sexual behaviour is the main goal.

A nationally representative task force of leading health, education and sexuality professionals developed the SIECUS Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade (Table No.4.4.2). These guidelines were designed as a framework to assist local communities in designing new curricula or assessing existing programmes (Moore and Rienzo, 2000). There was only one state level study that used these guidelines and thus further research is needed for their effectiveness.

Table No.4.4.2: Key concepts and topics in comprehensive sexuality education (Moore and Rienzo, 2000: 57)

Key Concept 1: Human Development	**Key Concept 4: Sexual Behaviour**
Reproductive anatomy and physiology	Sexuality through life
Reproduction	Masturbation
Puberty	Shared sexual behaviour
Body image	Abstinence
Sexual identity and orientation	Human sexual response
	Fantasy
	Sexual dysfunction
Key Concept 2: Relationships	**Key Concept 5: Sexual Health**
Families	Contraception
Love	Abortion
Dating	STDs and HIV infection
Marriage and lifetime commitments	Sexual abuse
Parenting	Reproductive health
Key Concept 3: Personal Skills	**Key Concepts 6: Society and Culture**
Values	Sexuality and society
Decision-making	Gender roles
Communication	Sexuality and the law
Assertiveness	Sexuality and religion
Negotiation	Diversity
Finding help	Sexuality and the arts
	Sexuality and the media

Standards for sexuality education were referred to earlier (Sex Education Forum, 1992). Standards are important as they provide health educators useful guidance for planning and are a means through which the outcomes of a programme, irrespective of the methods it used, can be measured. According to Kirby (1995:403) effective educational programmes have the following characteristics:

1. Narrow focus on reducing specific risky behaviour
2. Theoretical ground in social learning theory, social influence theories or theories of reasoned action
3. At least 14hours of instruction or instruction in small groups
4. Variety of interactive teaching methods as to encourage participants to personalized the information
5. Activities to convey the risks of unprotected sex and how to avoid them
6. Instructions on social pressures
7. Clear reinforcement of individual values and group norms appropriate to the age and experience of the students
8. Opportunities to practice communication and negotiation skills to increase confidence
9. Effective training for individuals implementing the programme

These characteristics or standards seem to be clear and comprehensive. However, one may argue that 'narrow focus on reducing specific risky behaviour', may be contradictory to health promotion concepts. Based on health promotion ideology, empowerment is the cardinal principle. One probably needs a wider perspective so as to try to control and/or improve his/her health. Health promotion focuses on positive health as to prevent ill health. Nevertheless, from an educational point of view, narrowing the focus may increase the possibility of effectiveness especially in adolescents, because it concentrates on a specific behaviour and its consequences. From a psychosocial point of view, a broader focus may fulfill adolescents' needs more adequately, as well as to identify any other problems they may have which related to sexuality issues.

Even within programmes which display what appear to be a clear standard, it is unclear how or whether this translates into effective practice in the classroom, nor who is the most effective in teaching sexuality education (Mellanby et al., 2001). Because programmes always face scarce resources (e.g. limited classroom time), educators must prioritize their goals and focus

on few outcomes. Too many goals are likely to result in superficial coverage of important issues (Kirby, 1992).

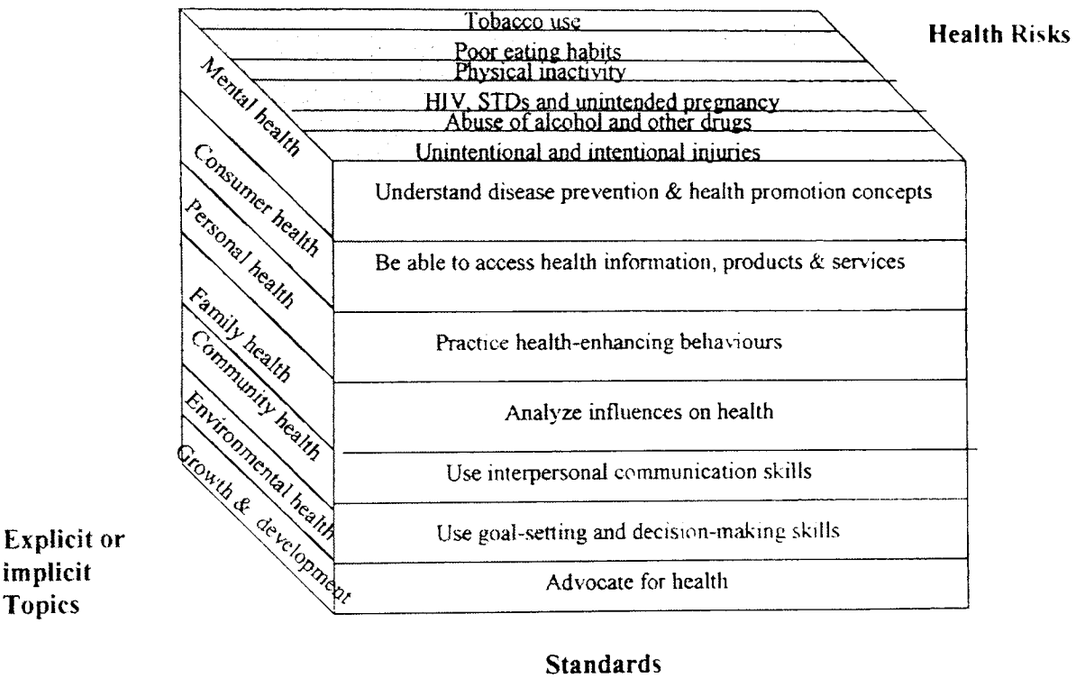
According to the National Health Education Standards (Kann et al., 2001: 266), within the spectrum of health education, students should be able to:

- Comprehend concepts related to health promotion and disease prevention
- Demonstrate the ability to access valid health information and health-promoting products and services
- Demonstrate the ability to practice health-enhancing behaviours and reduce health risks
- Analyze the influence of culture, media, technology and other factors on health
- Demonstrate the ability to use interpersonal communication skills to enhance health
- Demonstrate the ability to use goal-setting and decision-making skills to enhance health and
- Demonstrate the ability to advocate for personal, family and community health

National standards can be used as a framework for decisions about lessons, strategies, activities and types of assessment to include in health education curriculum. Health education curricula based on National Standards (Figure No.4.4.1), encourage students to use technology, art, science, mathematical skills in a health context. Health education has the potential to improve the academic achievement of adolescents as well as their health status (Lohrmann and Wooley, in Marx et al., 1998); and sexuality issues are included within the health education spectrum. In this way sexuality is seen as

a part of a healthy lifestyle. Thus, it is important to be cultivated within families, school and society.

Figure No.4.4.1: Standards-based health education curriculum (Lohrmann and Wooley in Marx et al., 1998:49)



Summary

Health promotion programmes are designed to influence health behaviour as to improve health status. To make healthy choices, easy choices for young people will require social and communal change and political action (Nutbeam et al., 1991). Health promotion programmes are designed to influence health beliefs, attitudes and behaviour as to improve health. The school is a small but important contributor in this. As previously mentioned, schools may not always have the ideal conditions but they offer a fruitful place for acquiring knowledge. It is essential that governmental and non-governmental organizations, policy makers and communities in general support this effort. Thus, healthy choices become easier choices.

This chapter discussed the concept of sexuality within the parameters of this study. As society and culture are essential factors regarding sexuality the following chapter will explore the Cypriot culture and society, since this study was undertaken in Cyprus.

CHAPTER 5

CYPRUS

Introduction

This chapter begins giving a historical and a political perspective of Cyprus. This is important to understand the influences that shaped Cypriot culture and identity. It then gives a brief demographic and political description of contemporary Cyprus with particular emphasis on sexuality, religion, internal politics, education and mass media.

5.1 Cyprus- A Historical and Political Perspective

Cyprus is a small island situated in the northeastern corner of the Mediterranean sea. It is about 40 miles from the coast of Turkey to the north, 60 miles from Syria to the east, 250 miles from Egypt to the south and 300 miles from the Greek islands to the west. The area of the island is 3.572 square miles. It stands at the crossroads of three continents- Asia, Africa and Europe. The greatest breath from north to south is about 60 miles and the greatest length from east to west is 140 miles, (Keshishian, 1990).

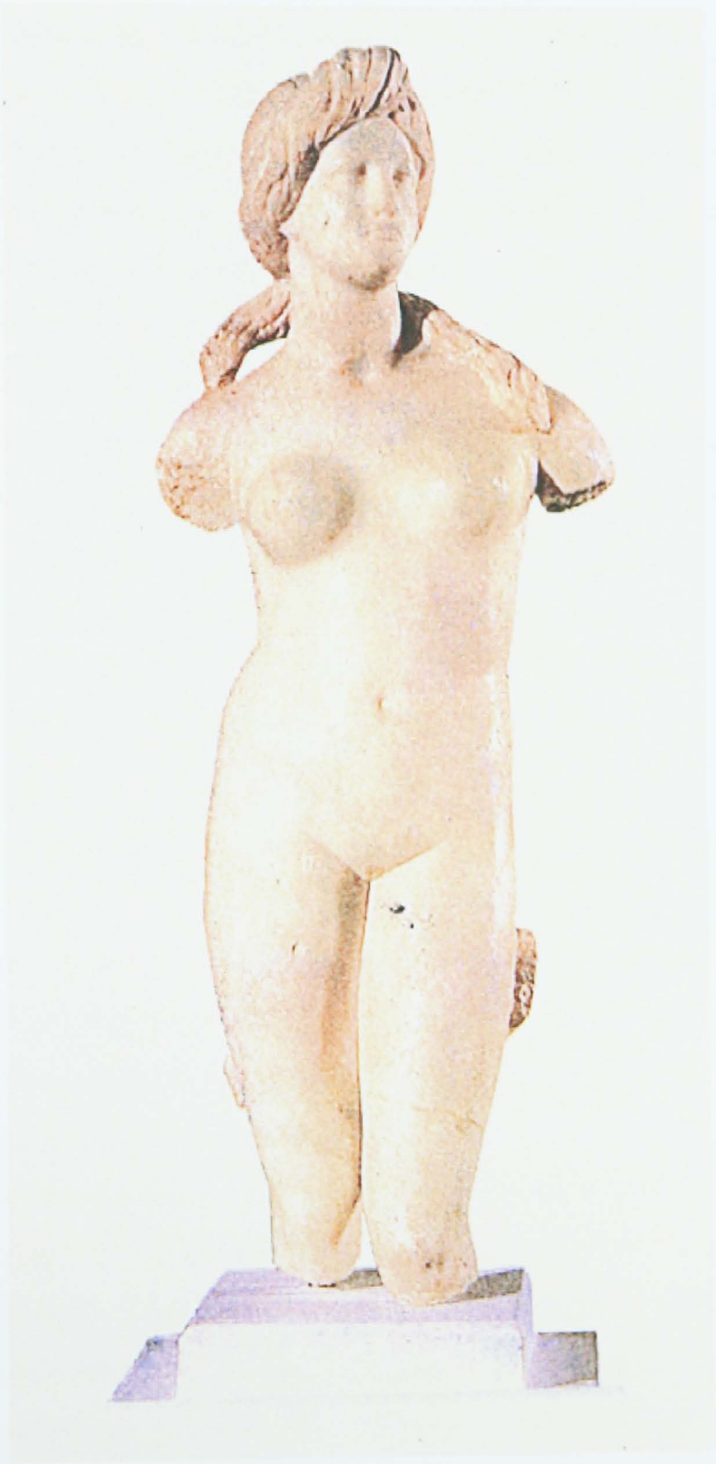
Cyprus has a rich cultural history. There is evidence of Cyprus civilization since 7^{th} millennium B.C. The first inhabitants probably came from the East coast of the Mediterranean sea, during the Neolithic Age. Cypriot women, at that era, except from being responsible for raising their children, they had to work in the fields as well as taking care of the animals they had in their homes (e.g. donkeys, chicken, cows etc). Some had to do crafts work too (HatziDemetriou, 1985). During the Bronze Age (2500-1050 B.C.) the Mycenaean and Achaean Greeks settled in Cyprus. Following the conclusion of the Trojan War, various legendary Greek heroes visited the island, where they were associated with the foundation of great cities such as Salamis, Kition, Kourion and Paphos. The language, customs and religion of the Greeks influenced Cypriots, shaping the Greek character of the population

that is preserved until these days. In the following years many civilizations passed and occupied Cyprus (e.g. Assyrians, Persians, Phoenicians).

Cyprus was a convenient crossroad to the Eastern countries. Alexander the Great included Cyprus in his empire (333-325 B.C.). During the Hellenistic period (325-58 B.C.) Cypriots seem to adore statues of different Gods, especially Aphrodite (Cyprus Tourism Organization, 1995). Cypriots believe that Aphrodite was born in Cyprus. Religious celebrations were performed to praise the Goddess of love, beauty and fertility. The marble statue of Aphrodite (Figure 5.1.1) is a symbol of the island even today. Beauty and femininity seemed to be of important value.

During 58-330 B.C Cyprus became part of the Roman Empire and when the Roman Empire was divided into West and East Empires (330-1191 A.D), Cyprus came under the Eastern, known as Byzantium, with Constandinople as its capital. However, gender roles seemed to remain unchanged: Men presented as soldiers, farmers and marines and women as housewives, land workers and crafts workers. The Byzantine Empire was dominated by the Greeks and this influence contributed to the continuation of the Greek culture in Cyprus (Larousse Encyclopedia of Ancient and Medieval History, 1966 ; Webster's Family Encyclopedia, 1991). Galatariotou (1993) stated that in the last two centuries of Byzantine rule in Cyprus, contact with Europe became increasingly pronounced due to the Crusades. Cyprus ports were used by the crusading armies as places for launching missions or resting after them, and as a safe place for refugees. Cyprus was also a convenient meeting place for negotiation between warring factions. Following different invasions and occupations of the island between the 12^{th} and the 15^{th} Centuries A.D. [Richard the Lionheart (1191-1192 A.D.), Louisianans (1192-1489 A.D.), Venetians (1489-1571)] Cyprus became part of the Ottoman Empire in 1571. Dionyssiou (1993) wrote that the three centuries of Ottoman rule was an era characterized by a total lack of progress, the result of mal-administration and exploitation of the population.

Figure No.5.1.1: The marble statue of Aphrodite 1st century B.C. (Cyprus Tourism Organization, 1995:4)



The role of the woman in the Ottoman Empire was even more conservative than in the previous years. A traveler wrote that "...Greek and Turkish people keep their wives in distant places, isolated, where it is impossible for anyone to see them. Those (Greek women) I met on the streets were covered under a white sheet exactly like Turkish women..." (Hatzidemitriou, 1985:272). In addition, in female schools only women teachers were allowed to teach. Despite the hardships of Ottoman rule, the Greek-Cypriots preserved their cultural identity by remaining attached to their religion and language. This was because despite many difficulties and obstacles to education during this era was under the influence and supervision of the Christian church. Most of the teachers were priests (HatziDemetriou, 1985).

In 1878 Britain took over Cyprus with the agreement of the Ottoman Empire. In 1923 under the Treaty of Lausanne, Turkey renounced any claim to Cyprus (Cyprus Tourism Organization, 1995). Two years later the island became a British colony. Education in the island in these years was inevitably affected by the fact that after the 1933 Education Act, the Governor rather than the church became the central authority for all matters relating to the elementary education (Apostolidou, 1999). Nevertheless, the church was still a leading feature of the political life of the island. Furthermore, an important percentage of illiteracy was recorded, the majority of which were women and people of older age. Female teachers were obliged to resign from their jobs, after they got married (HatziDemetriou, 1985), probably in order to care for their husband, children and the home, all of which were thought to be their 'duty' while males were considered the breadwinners.

An armed liberation struggle broke out in 1955, demanding freedom from Britain and 'enosis' (to become part of Greece). In 1960 according to the Zurich-London Treaty, Cyprus became an independent republic. The first president of Cyprus was Archbishop Makarios III. Having the head of Church at the highest political position, the church acquired even more power. Archbishop Makarios III remained the president until his death in 1977. During this long period, Archbishop Makarios III, a dynamic and charismatic figure

had an enormous impact within the everyday culture of the Cypriot people. Soon after the independence in 1963, the inter-communal troubles began (between Greek-Cypriots and Turkish-Cypriots). The 1960's Constitution divided the people into two communities on the basis of ethnic origin and the Turkish-Cypriot minority was given rights disproportionate to its size. Archbishop Makarios III in his sincere desire to improve the situation, suggested several amendments to the Constitution that were rejected by the Turkish government and Turkish-Cypriot leadership. In addition, the Turkish ministers withdrew from the joint Cypriot Cabinet. Inter-communal violence as cultivated by the Turkish-Cypriot leadership was aiming at persuading world public opinion that Turkish-Cypriots could not co-exist with Greek-Cypriots and therefore partition in one form or another was necessary. In March 1964 a Security Council's resolution set the base for the involvement and presence of the United Nations in Cyprus (Apostolidou, 1999; Zacharia, 1999 ; Hatzidemetriou, 1985).

In 1974, a coup was staged in Cyprus by the right wing pro-enosis group supported by the Military junta, then in power in Greece. Turkey, responding to calls from the Turkish-Cypriot leadership, invaded the island. Over 200,000 Greek-Cypriots from the north and east became refugees and moved to the south and 45.000 Turkish-Cypriots from the south moved to the north. Since then the Turks occupy 35.4% of the island. A further 1.8% forms part of the buffer zone along the cease-fire line, the so called Green Line (www.pio.gov.cy, 2002). There was no access for Greek-Cypriots to the occupied part of the island between 1974-2003, when limited access became possible. Efforts to find a solution to the international problem posed by the division of Cyprus continue under the auspices of the United Nations Secretary-General. Despite the political situation, the international recognized legitimate state of Cyprus (southwest of the island) has had a successful economic development. Agriculture and tourism are the major elements of employment and financial returns.

In general, it could be deduced that the fundamental planks of the Greek Cypriot culture are composed of a pride in the Greek heritage, the value for freedom and independence, the Christian values, and the Greek language. Furthermore, the years of 'foreign occupations' gave the Greek Cypriot people a common goal, that of fighting for independence and striving to maintain their identity. Triandis (1989) characterizes societies with common goals, as 'collectivist' societies. Such societies retain a strong sense of cultural identity, which is tied to family, nation and gender. They value the welfare of others, they respect and honour their parents and elders, pay attention to a positive public image of themselves and their families, and feel shame as a result of wrongdoing. Such values are compatible with the Christian values, thus Christianity may reinforce the notions of collectivist culture particularly during times of oppression. Indeed, as outlined above, during the years of the Ottoman occupation of Cyprus, it was the Christian church and its leaders that kept the flame of the Greek Cypriot identity from being extinguished, through secret schools and through acts of defiance, which often caused the death of some clerics.

During all these years and up to the 20th century, particularly in the rural areas of Cyprus, the male dominant character still existed. For example, women were dressed with long dresses and wore a scarf on their heads, in order to maintain limited or no exposure of their bodies. They were expected to avoid any eye contact with males. Chastity was the ultimate goal. In Greek ethnography (which is very much similar to Greek-Cypriot) women are often described as being marginal and muted (Loizos and Papataxiarchis, 1991). Many women wish to become good housewives especially in rural areas (Loizos and Papataxiarchis, 1991).

Even when women began to work outside the home, women's role was undermined (Hatzidemetriou, 1985). The ancient practice of arranged marriages still continued and most of the times it was expected that a woman had to have a dowry, in the form of property such as a house or land. It was

also expected from women to prove their virginity at the first wedding night as well as for the men to prove their manhood. The custom used to be to hang outside in the yard the blood stained sheet used during the first wedding night. This custom continued to be practiced until the middle of the 20th century. Virginity will be explored later in this chapter.

It is also important to mention that education about sexuality was limited or non-existent depending on the open-mindness of the schoolteachers, school doctor or nurse. There is evidence that certain secondary (high) school students were given some knowledge about sexuality matters. Dr Kypros Chrysanthis has a rich published work related to health education in Cypriot schools from 1940 until early 1980. Dr Chrysanthis was a Paediatrician-Pathologist and Director of the School Medical Services. There is no extensive report on sexuality issues but there is an important and pioneering contribution to the concept of sexuality education. Some of the themes that he researched and explored were: Anatomy and physiology of the reproductive systems, menstruation, dysmenorrhoea, adolescence, personal hygiene, sexuality education in school and others. In his report about 'genetic education' (that is how he called it) he suggested that for male students this should begin at 16 years of age and for female students just before menarche. He noted that, for girls, other topics than menstruation could be taught in private (in a later age) only to those who intended to work outside the home. It could be argued that he assumed that girls working outside home had different needs regarding knowledge about sexuality than those staying at home. This may be due to the male dominated Cypriot society viewed that women outside the home were tempted to commit 'sins' and therefore could not be trusted especially by men. At this point of time it is a fact that Cypriot society preferred women to stay at home. It was, somehow, more appropriate or acceptable. Arguably, religion has always been very influential to Cypriots, thus Christianity views for women have a role to play in gender behaviour. In the Old and New Testaments women are presented variously as subordinates, honorary superiors and spiritual mediators. Proper women are

deprived to express themselves but rather may led to non-verbal expressions (Loizos and Papataxiarchis, 1991).

According to Chrysanthis (1977), the doctor was considered to be the most appropriate person to teach these topics for both genders; for female students a female doctor was suggested. These ideas were very modern and pioneering for that time, even though the emphasis was on the biological part of sexuality. Moreover, Dr Chrysanthis mentioned that the only prevention from Sexually Transmitted Infections was marriage and temperance. He added that masturbation was reported as inappropriate adolescence behaviour. He also reported that, "...there are several cases of young males (20-24 years old) who got married because they did not dare to go to prostitutes or elsewhere" (Chrysanthis, 1977:125). This creates different arguments such as promoting marriage as prevention to STI's. Through his writings there is overemphasis to male sexual needs. One could also argue that, many young people got married just to avoid people's gossip and behave 'culturally appropriately'. However, all these may suppress one's feelings and sexual desires. According to Dubisch (in Loizos and Papataxiarchis, 1991) a Greek man cannot achieve full adult status until he is married. Shame (dropi) is of important value for Greek people. Thus sometimes people may do/say things as to avoid shame or loose their honor. No further records of the female gender role as sexual being were found, because it was probably thought that women have less or no sexual needs. Their sexual expressions are shaped and controlled by men (their husbands).

Throughout the years Cypriot culture has changed: Arranged marriages have nearly been stopped and the proof of virginity on the wedding night is abandoned. Despite these, conservativeness for sexuality issues, among many Cypriots, still exists; for example single parenting (especially when it happens outside wedlock) or cohabitation are not easily accepted by most of the Cypriot people.

5.2 Contemporary Cyprus

According to the world factbook prepared by the Central Intelligence Agency (CIA, 2002) the estimated population of Cyprus in 2001 was 762,887, of who 78% are of Greek origin, 18% are of Turkish origin and 4% are Maronites, Armenians, English and a number of other ethnic groups. There are fewer females as compared to males in all age groups except those of 65 and over. The sex ratio at birth is 1.05 males to 1 female. Infant mortality rate is 7.89 per 1000 live births, whilst the total fertility rate is 1.93 children born per woman.

Except from the estimated population figures for Cyprus, the remaining statistics are referring only to the southern part of Cyprus. The main religion on the island is Greek Orthodox Christianity, but other minority religious groups exist such as Muslims. Christianity was preached in Cyprus in 45 A.D. by the Apostoles Paul and Barnabas. The Proconsul Sergius Paul was converted to Christianity and Cyprus became the first country to be governed by a Christian. The church played an important role in every sphere of the island's life (Apostolidou, 1999). It was significant that Cypriots successfully fought to maintain the independence of their church and thus became one of the oldest autocephalous churches of the Eastern Orthodox Church (Dodd, 1999).

The languages used are Greek and Turkish, but English is very widely spoken too. Cyprus has six districts: Nicosia (which is the capital), Limassol, Larnaca, Paphos, Kyreneia and Amohostos (Famagusta). A northern quarter of Nicosia, 95% of Amohostos and the whole district of Kyreneia are under Turkish occupation.

Cyprus has a typical Eastern Mediterranean climate, with mild wet winters and hot dry summers. Although it often suffers from drought, 50% of its land is arable and produces fruits, olives, grapes and vegetables (Apostolidou, 1999).

Despite the continuing political conflict between the Greek and Turkish-Cypriots which maintains the geographical division of Cyprus, the economy of the south of the island, which constitutes the internationally recognized Republic of Cyprus, is prosperous but highly susceptible to external forces, particularly tourist arrivals which are in turn dependent on the economies of the countries from which Cyprus attracts most of its tourists. Tourism is the source of 71.3% of Gross Domestic Product (CIA, 2002). This prosperity has resulted in many and rapid changes of the Greek-Cypriot society and its culture. Greek-Cypriots have become much more cosmopolitan. Although, as it was discussed in the previous section, Cyprus has always been a place where different cultures met, the relationship which Cypriot people had with their 'rulers' was different to the relationship they now have with their 'visitors'. Cypriots are now much more able to travel abroad for holidays, business, and to study. The relative stability and prosperity of Cyprus, has attracted a number of Easter Europeans and people from the ex-Soviet Union to Cyprus to work and settle. Labour shortages have also attracted people from India, Pakistan and the Far East to Cyprus. Thus, contemporary Cyprus is gradually becoming a multicultural society. For example, mixed marriages are not an unusual phenomenon and changes are seen to family structure too. New ideas are introduced to the Cypriot society not only due to this but also due to the preparation of its entry to the European Union.

Cyprus from the early 70's expressed its interest and desire for the Acquis Communautaire, which includes: the aims and objectives of Treaties between member-states of E.U., the legislation adopted by member-states within the E.U., the jurisprudence of the court of the European Communities and the international agreements between E.U., member states and other organizations. Cyprus is one of the candidate countries for the enlargement of the European Union in 2004.

All these changes and challenges affect every aspect of Cypriot society-sexuality, religion, politics, education, mass media and generally health and culture. These issues will be explored throughout this chapter.

5.2.1 Sexuality Issues in Contemporary Cyprus

In the past two years (2000/2001) the media reported many cases related to sexuality matters (e.g. sexual abuse, sexual assault to adolescents, rape etc) and this is of major concern. During the period between 1/1/2001-31/8/2001, 128 cases (75 girls and 53 boys) of abuse of young children have been reported, most of them in Limassol. In 1998, 12 cases of sexual harassment were reported, whilst in 2000 there was an increase to 28 cases (Antenna, 2002). However, there is no research evidence of the primary cause of these. Arguably, some of these cases have probably always happened but remained unreported due to the secrecy of society on these matters. Nowadays, the higher and advanced education of the majority of the Cypriots, the plethora of the media, the socio-cultural transformations such as gender roles, the multicultural environment gives to some people the courage to come forward when personal problems occur especially related to sexuality. The existing taboos for sexuality issues though and stigmatization make others reluctant to express and reveal such problems when they exist within the family environment. According to the Association for the Prevention and Handling of Domestic Violence (2000), during the year 2000 (January-November 2000) 590 victims (492 women, 38 adolescents, 47 children, 13 men) of physical and/or sexual violence asked for psychological support, counseling or shelter.

Despite the decrease of new HIV/AIDS cases since 1994, in 2000 an increase has been recorded again (Table No.5.2.1, Ministry of Health, 2000). Substance misuse also seems to be reaching its highest levels for Cyprus. More than 20,000 people (between ages 15-60) have tried cannabis at least once in their lives (Demetriou, 2001). The particular report goes further to state that there is an increase of the intravenous drug users in the island too. This increases the chance for unsafe sexual behaviour that can harm one's self and others.

Table No.5.2.1: Brief HIV/AIDS data from 1986 - December 2000 in Cyprus

SUMMARY INFORMATION ON HIV/AIDS – CYPRUS, FROM 1986 TO DECEMBER 2000																		
New cases by the year	Yearly average	23		1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	N-00
	Cypriots	14	Total (354)	11	17	16	24	16	22	24	24	39	35	28	27	19	23	29
	Foreigners	9	Cypriots (213)	6	11	12	14	5	14	9	14	29	20	17	15	15	14	18
	Downward trend since 1994		Foreigners (141	5	6	4	10	11	8	15	10	10	15	11	12	4	9	11
Estimated number of HIV infected people currently living in Cyprus	* 300 - 500 (information evaluated in co-operation with HIV/AIDS) * Corresponds to a rate of 0,06% to 0,1% in the 15-49 year-old population * In relation to world estimates: 1/10 of crude world rate, 1/90 of rate of Sub Saharan Africa, 1/16 of rate of North America, 1/4 of rate of Eastern Europe, less than 3/2 of rate of Western Europe and 1/2 of rate of Middle East																	
Place of infection for Cypriot seropositives	Percentage of Cypriots infected in Cyprus (based on known cases)								Before 1993 14% of all cases Between 1993 and 1999 56% of all cases									
Mode of transmission for Cypriot seropositives (percent distribution)	Sexual contact in 90% of cases		Heterusexual 44% Homosexual 45%						Other modes of transmission		IVDU Perinatal Blood and products Unidefined	2% 1% 4% 4%						
Age distribution (Cypriot	80% of Cypriot seropositives were aged 20 to 40 at diagnosis																	
Sex distribution (Cypriots	Men 183		Women 30						Sex ratio Men:Women 6,1:1		Two children among seopositives one of them infected perinatally, the other probably through blood abroad							
AIDS (C-CDC 93 case definition)	AIDS cases 121 (included in the 354 - the remaining cases are asymptomatic)		Men Women Children	106 15 0					Deaths from AIDS 53 (included in the 354)		Men Women Children	46 7 0						

As Cyprus is a small society, it is inevitable that its people are influenced by gossip. It is characteristic that the reputation of a woman is often a criterion for marriage, even though this attitude is somehow fading. Dowry, as mentioned in the previous section, was a criterion for marriage as well. This cultural practice is not totally abandoned by some people even in 21st century. According to the findings of a study conducted by the Cyprus Youth Organization (1997), 30.6% of the young participants (ages 15-19) believe that a dowry is necessary for a new couple to survive.

As mentioned earlier in this chapter, traditional Cyprus is a collectivist culture, where people give priority to in-group goals. The self is defined in terms of membership in groups that influence social behaviour (Triandis, 1994). To know more about others than about self, as an attribute of collectivism, gives an explanation of gossip. For example, in Cyprus, if there is a mental illness in the family people tend to hide it because they will be marginalized; or if a young unmarried girl got pregnant, abortion might be an option to avoid stigmatization from the society. In contrast to these, in individualistic cultures (e.g. U.S.A.) the individual is the figure and self is defined as an independent identity (Triandis, 1994). Individualists do not show extremes of subordinate or superordinate behaviour, while often collectivists do.

Furthermore, the relatively strong family ties sometimes impose difficulties on discussing or even mentioning issues of personhood within the family such as sexuality. For example, in October 2001 an eighteen-year old girl gave birth alone in her parents' house. The baby died (Filelefttheros, 2001a). Also, there are reported cases of adolescent girls that were pregnant and did not even realize it (Filelefttheros, 2000). It could be argued that these may be extreme cases, but such cases are more and more often seen in the media. On one hand, this can be due to the development of the mass media in Cyprus. On the other hand, this may indicate an alteration of adolescent sexual behaviour resulting in an increase of such cases. It must be repeated that due to limited local research in adolescent sexuality there is lack of important data.

Although the Cypriot society is changing and people are becoming more sensitive and aware of sexuality matters, there are still many Cypriots that feel uncomfortable and consider the expression and discussion of such issues within or outside the family to be unethical. One may argue that, there is a need for sexuality awareness- information, knowledge, support and guidance for Cypriots, especially young people, in these sensitive issues. Otherwise, there will be a steady increase of problems such as unwanted pregnancies and HIV/AIDS. However, education will not alone solve the problem. Attitudes, values and beliefs that have been adopted and shaped within Cypriot culture, have a stronger impact on behaviour than just the possession of knowledge. Thus, in promoting health one should give emphasis to these parameters.

Many factors influence attitude formation and change such as religion, internal politics, education, mass media and globalization.

1) Greek Orthodox church

As previously mentioned, the church in Cyprus has enormous power and influence within everyday life that cannot be ignored. Virginity (mostly for females) is an issue for many people in Cyprus. The Church believes in the virginity of both genders. According to a study conducted by the Cyprus College Research Department (2001), an important percentage of the population (41%) is against a woman having premarital sex, while participants were more accepting of men having premarital sex. It is interesting to report that only 9% of the participants between the ages of 18-24 considered it wrong having premarital sex. Similar findings have been reported by the Research and Development Department of Intercollege (2000); that 79% agreed or strongly agreed that 'men should be free to have premarital sex', whereas only 46% agreed or strongly agreed with that statement for females. Somehow, society seemed to have different criteria of moral behaviour according to gender, despite the fact that the church supports male and female chastity. Furthermore, the gender roles within the Cypriot culture have

an impact on the expression of boys' and girls' sexuality. Cyprus is mainly a male-dominated society. It is more acceptable for males to have sexual adventures than females. It could be argued that education, traveling, Europeanization and the many years of deep conservativeness of the Cypriot society, especially in sexuality matters are some of the factors that had an impact on the attitudes and behaviour of mainly younger people towards sexuality as seen through the studies mentioned above. It is not that people do not value honor or do not feel shame for 'inappropriate behaviour' rather than are more assertive and more pragmatic within contemporary Cypriot society.

The church until recently (1999) used to hold a ceremony for engagement. During a short ceremony, the priest was blessing the couple and their rings at the church or sometimes at the house of the bride. It is a custom also, after this event, for the family and friends to have a party (dinner and/or dancing). The couple (after the engagement) usually stays at the house of the bride's parents or in their own house usually for practicality and economic reasons. Some couples choose not to live together until their wedding day due to their religious beliefs. The period of engagement varies from few months to few years. The church has now forbidden this ceremony as they implied that this has encouraged premarital sexual relationships, which was not the intention of the ceremony, since premarital sex is considered as a sin (Church of Cyprus, 30/9/1999). Church representatives felt responsible for encouraging young people to cohabit (through the engagement ceremony) and thus, have premarital sex. However, by forbidding it the primary aim of the church (discourage premarital sex) has not been achieved. Perhaps instead of abandoning the ceremony priests could have taken the opportunity to explore some issues with the couple before or after the engagement ceremony. Some priests occasionally do this during wedding ceremonies.

In 1990 there was a strong reaction from the church against the introduction of civil marriage. It was argued that marriages must always be under the umbrella of the church. This will be discussed later in this chapter under politics and legal issues. The church also does not officially accept homosexuality, termination of pregnancy and contraception. Chastity, faith and virtue must be kept and encouraged (Regional Conference-East Mediterranean-on Religion and Morality for Prevention and Control of HIV/ AIDS and STI's, 1992). However, the church seems to compromise with the realities of the contemporary society. Often the interpretation of the official position of the church differs amongst priests and the way they advice their congregation.

Abortion is another controversial issue in Cyprus. The church is strongly against abortion even in rape, while the law under certain circumstances allows it. Thus, there are important differences between the law and the church. This is certainly a confusing issue for Cypriot people, especially for adolescents. One's own personal beliefs and how much she/he is influenced by church and society will finally form one's decision for or against abortion (at a particular time and under certain circumstances). A discussion on the legal aspect of it will follow. Nevertheless, there are cases that church helped, financially and psychologically, women that were raped to give birth to their children as well as unmarried women (Vasiliou, 2001). The church is certainly pro-life. Even recently the church took a formal stand on the issue of termination of pregnancy "...church confirms its position that life begins from conception, meaning fertilization, and demands respect and protection from this moment and after...contraception is a sin, since is an act of killing an innocent human being..." (Church of Cyprus, 28/2/2002). Cyprus church seems to have a rigid position on sexuality issues, even with the vast changes of Cypriot society and the position of the law. It is understandable that it is difficult for the church to move from its position.

Another matter that was very much argued in the past decade and still is, is homosexuality. The church or generally Orthodoxy does not reject the person but the behaviour (e.g. homosexuality). The church will support a person if he/she asks for forgiveness for a behaviour that is not accepted within the preaching of Orthodoxy.

When Cypriot parliamentarians were deciding for the decriminalization of homosexuality in 1998 (see below) there was a dynamic opposition from the church representatives. Many times the politics and the legal system in Cyprus are very much influenced by the church. However, politicians have made decisions on critical social matters within the evolution of the Cypriot society and under the pressure of the process of entry in the European Union.

2) Political and Legal Issues

In 1990, the Law (Section) 21/90 about civil weddings was passed, even though there was a strong reaction from church. The present law paradoxically, for Cypriot society, states that a civil wedding can be performed between two persons that belong to the Greek community. The particular law does not mention anything about gender, even though it is believed that this was done unintentionally. Meaning that it was assumed, that marriage would only be performed between a man and a woman. Therefore, same sex marriages are not against the present law. The newly proposed Bill (2001:1) is more conservative on this point and confirms the Greek-Cypriot cultural attitudes towards weddings. It states clearly that '...wedding means the civil marriage between a man and a woman...'. This comes in contrast with the European Community's decision about equality of homosexuals, including same gender marriage. Already Cyprus is facing this problem and European parliamentarians have discussed this issue with their Cypriots colleagues (Filefeftheros, 2001b). However, it must be noted that in most E.U. member-states same sex marriage is not permitted yet.

The majority of Cypriot people perform religious weddings. If a couple is to get a divorce, this must be done through both, the church and the family

court. If a couple has performed a civil wedding then has to have a divorce from the family court only.

A more difficult challenge for the parliamentarians was homosexuality. Despite the opponent position of church representatives, in 1998, the House of Parliament voted for the decriminalization of homosexuality, after the leader of homosexual movement in Cyprus (Mr Alekos Modinos) sued the government at the European court.

One could argue that sometimes, the Cypriot legal system can be disappointing in the way that sexuality matters, crimes or offences are viewed, because one could argue that sentences for these crimes have been fairly light. The very recent case (2003) of a thirty-seven year old male is only one example of this. The accusations were for sexual assault, rape and kidnap of an underage girl during the period of 1999-2000. He was given a four years prison sentence. He will probably spend much less time in prison with showing 'good behaviour'. Arguably, the main reason that the girl did not come forward before now was the stigmatization from the society. This may suggests that sexuality issues are becoming less of a taboo. It must be noted that he was convicted with the previous law since the offences preceded the new law (N.3(I)/2000). In the present law a person found guilty of sexual assault of under-aged individuals, may be given a prison sentence for up to twenty years. This is an important factor showing that the Cypriot government and society are acknowledging the problem and taking sexuality crimes very seriously.

Abortion seems to be increasing among adolescents in contemporary Cypriot society, although there is lack of scientific evidence to know the extent of the problem. This input comes from the experience of Obstetricians and Gynaecologists, the secondary school teachers and the CFPA. A woman parliamentarian suggested in September 2001 the decriminalization of abortion. The government representative stated that there is no such intention

at this time nor is there an intention for criminal charges to anyone involved in such act (Vasiliou, 2001). This indicates a silent acceptance. Abortions were only allowed after the Turkish invasion in 1974 in cases of rape (the law changed at that time). In a study undertaken by the Research and Development Department of Intercollege (2000), 38% of the participants agreed or strongly agreed that abortion is a woman's right, whereas 55% disagreed or strongly disagreed with that.

It is important to note that the present law allows abortion after:

1) it is confirmed by the police and the medical services that pregnancy is due to rape and under circumstances that will cause a serious crisis of the woman's or her family's social position

2) a medical consultation of two doctors, if the physical, mental or psychological state of the mother is threatened or there is a serious problem within the family environment or there is the danger of severe abnormality of the foetus (Penal Code 169A).

Still the law leaves an open window for termination of pregnancy under the '...physical, mental or psychological state of the mother is threatened...'. It is interesting that termination of pregnancy in Cyprus public hospitals are rarely performed and when they do are mostly due to genetic defects of the foetus. In private hospitals or clinics this is more often done and genetic defects is not the only reason. One may argue that, doctors in public hospitals decide to terminate a pregnancy with more difficulty, probably because of the influences or control by the government, church and society. Public health services are always under assessment, evaluation and control, while this is rare for private institutions. Women may prefer private hospitals or clinics because of more privacy and less bureaucratic procedures or may be because decisions for terminating a pregnancy are easier taken. According to the Cyprus Statistical Service (2000a), 28 medical abortions were carried out in the year of 2000, 90% of which were between the ages of 15-44. The statistics refer only to the public hospitals in Cyprus. There is no official data for private clinics or hospitals.

For the last two years sexuality education has been on the Cyprus political agenda more intensively. It is positive that there is a more serious attempt for political involvement, even though it may not be the ideal, since too much bureaucracy may delay decisions. Although this is a democratic procedure the world is changing fast, the needs are immediate and progressive decisions and their implementation is crucial. Cypriot people have an advantage- they can be taught from the successes and failures of other countries in promoting sexual health and prevent unwanted conditions. The House of Parliament and especially the Parliamentary Committee on Education in cooperation with other interested parties (e.g. Family Planning Organization, Cyprus Medical Association, Parents Association, Psychologists etc) had some discussions on sexuality education in schools. The different groups have expressed their views, thoughts and hesitations for what and how it should be done and who is going to implement this programme. The diversity of opinions is influencing dramatically the final decision about sexuality education. For example, who is eligible to teach sexuality education; some argue that doctors (mainly gynecologists) could do it, social workers and psychologists want to be involved whilst the Ministry of Education and Culture prefers secondary school educators (e.g. biologists, home economics teachers etc.) to do this. The Ministry of Education and Culture has the leading role in evaluating and analyzing this programme, within the framework of health education.

3) Education and Resources

Even though there are a variety of international studies on the field (e.g. Mellenby et al., 2001; Mellenby et al., 1995; Wellings et al., 1995; Kirby, 1992) still local research must be conducted. It is not an easy topic to research, especially in a small society such as Cyprus. Some of the reasons that create this difficulty are: The existence of many bureaucratic procedures, conservativeness or lack of initiatives from people especially in leading positions, politically driven decisions and taboos. Despite all these,

researching the field of sexuality in Cyprus is not impossible. Any decision taken for different prevention or intervention programmes must be based theoretically and research based. Detorakis (1992) supported the view that sexuality programmes must be studied scientifically and very thoroughly. Otherwise, it will not only cost time and of human resources but money too, in spite of the good intention of an educational programme. For example, it is believed that there is a serious problem of unwanted pregnancies in certain areas of Cyprus, but there is no evidence of it. Therefore, whatever health education programme may be applied it will probably not be completely successful. Having evidence may reveal the cause of a problem and therefore, a more suitable intervention will be implemented. In addition, research may identify other aspects of a problem or even other problems. For example, there are specific areas in Cyprus that are major attraction places mainly for young tourists. Consequently, young males (mainly) are attracted to these particular places. This is probably because of the reputation that casual sex, long lasting parties and drugs are easier to find. However, there is no research to support this.

Research-based evidence will help in developing a well-planned programme according to the needs of the specific population at that time and/or place. Moreover, differences in culture must be taken into consideration as well as differences within Cyprus (e.g. different cities). It is the researcher's assumption that each city has its own 'cultural identity', meaning that people have some cultural differences from one city to another. For example, Limassol attracts lots of young tourists and many Russian immigrants choose to live there. Limassol is also famous for its nightlife, whilst Paphos attracts more mature tourists and many Russian-Pontious or Greek-Pontious immigrants. Ayia Napa (part of the district of Amohostos) is mainly preferred for its summer nightlife by young people (either tourists or Cypriots). Nicosia is considered more as a business place, with spoiled young people. Therefore, young people have some different stimuli and cultural influences in different places in Cyprus.

There is a limited number of experts on sexuality education in Cyprus, meaning people that have researched Greek-Cypriot sexuality, taught sexuality issues and have experience with young people regarding their needs, attitudes and behaviour. There is also limited cooperation and collaboration between the different governmental departments. For example, the sex education programme that is included in the school health education programme, is under the Ministry of Education and Culture. One could argue that, the Ministry of Health should be concerned about sexuality education but to date its involvement is almost non-existent. However, there are nurses in schools (called Health Visitors in Cyprus) that often organize discussions or lectures on sexuality issues (e.g. HIV/AIDS, puberty). Each Health Visitor covers on average five schools (approximately 1,500 students). Thus, in practice the Ministry of Health and the Ministry of Education and Culture are involved with sexuality issues. Arguably, a comprehensive programme with good organization and close collaboration of both Ministries will probably improve sexuality education.

Furthermore, there are very few services that promote sexual health for adolescents. Some helplines are available (e.g. crisis line for domestic violence, 'youth for youth' line of the CFPA), but there is only one organization that offers services for sexuality issues- the Cyprus Family Planning Association.

CFPA is a non-governmental, non-profit organization with limited financial resources. The government funds the CFPA with C£28,000 yearly. This money comes from the Ministry of Health, the Ministry of Labour and Social Security, the Ministry of Justice and also the Cyprus Youth Organization. It is obvious that limited activities can be done with this financial support. Furthermore, the services of the CFPA are offered only in Nicosia due to economic constraints. However, the Cyprus Family Planning Association (CFPA), being pioneer, has already developed a youth friendly service in Nicosia. It operates one day a week between 15:00 hours-19:00 hours and

having as providers- members of the youth group, a specialized nurse, a clinical psychologist and a doctor. This youth friendly service provides advice, counseling and clinical services (e.g. HIV/AIDS testing, pregnancy test, contraception etc.) regarding sexuality. There is male and female staff at all times. Information and services are offered upon request throughout the week. Obviously the CFPA services are not enough. It is however, a significant contribution to the improvement of Cypriot adolescents' sexual health.

It is important to note that one can also get information and services (e.g. cervical smear, HIV/AIDS test) through the National Health System of Cyprus. Arguably, the system practically cannot be useful for adolescents, since it is accessible until 14:30 hrs, when the majority of adolescents are in school, and not during afternoons or weekends. Also, not all citizens are offered free services in the Cyprus NHS and there is less privacy than in the private hospitals or clinics. In public hospitals one has to complete forms with personal details that many people can have access to them and since Cyprus is a small country, it is not unusual for people to know each other. Also, many times people have to wait for hours in order to be seen by a doctor.

Private doctors or hospitals provide health services too but they are more expensive those provided by the public hospitals. Young people often use the money that their parents give them for different reasons (e.g. shopping, school etc.) to obtain sexual health care. Poorer adolescents either work or borrow money from friends.

Despite the fact that some improvements have been made in sexual and reproductive health (with the introduction of health education in schools), sexuality education remains a controversial issue.

Sexuality-Family Education (as it is officially known) was formally included as one of the nine units in the Health Education Curriculum in 1992. At the time, it was suggested that this new curriculum be taught to all levels of Cyprus Education (Ministry of Education and Culture, 1991), meaning primary and secondary education.

The nine chapters or units were:

1. My Body
2. My Self
3. Nutritional Habits
4. Use and Abuse of Substances
5. General way of life
6. Environment
7. Safety
8. Physical exercise- Athletics
9. Sexuality-Family Education

The aim of Unit nine 'Sexuality- Family Education' is to enable students to:

- develop knowledge of anatomy and physiology of the reproductive system
- demonstrate responsible sexual behaviour
- protect oneself from the dangers of casual sexual behaviour
- strengthen the family institution and belongingness and an understanding of the family as a foundation stone of society and support system for the individual.

The Ministry of Education and Culture (1991) suggested that the following areas are included in unit nine of the Health Education curriculum in order to achieve the aims of the course:

-Anatomy and physiology of male and female reproductive systems and their development

-Development from conception to delivery/birth

-Care and health of the infant

-Care and health of the child

-Adolescence- care of the body, guidance and preparation for adulthood, masturbation, psychosexual identity, sexual deviations

-Normal sexual relationship (between a male and a female), love, partner selection and the family

-Family relationships

-Respect of the two genders, relationships, equality, unwanted pregnancy

-Sexually Transmitted Infections, HIV/AIDS

(Ministry of Education and Culture, 1991).

Some of the topics (e.g. anatomy and physiology) seem to be covered knowledge-wise more extensively, while others seem to be less emphasized, such as psychosocial aspect of human relationships and sexuality. These might be the most important aspect of this programme. Moreover, some topics are taught in primary school (mainly anatomy and physiology) and in secondary school (second grade) are taught on a regular basis. Mainly biologists and home economics educators teach the different topics in secondary school. The whole programme seems to cover a variety of issues concerned with sexuality, but still can be explored and improved. For example, the curriculum underlines the male and female relationship, leading to marriage and family. Thus, marriage seems to be an obligation rather than an option. However, there is no reported evaluation of this curriculum application. There are efforts though by the Ministry of Education and Culture and other interested groups, such as the Family Planning, for reforming the unit on sexuality, but nothing is formal or final as yet.

Nevertheless, the Ministry of Education and Culture has recently (December 2001) decided to pilot a new sexuality education programme in three schools in two cities based mainly on a small number of British studies. However, this has not been implemented during the year 2001 and was applied in the academic year 2002-2003 with some variations. Two programmes were piloted instead of one in three different schools for each programme.

The first proposed programme has a multi-thematic approach involving educators/teachers from different backgrounds- Theology, Biology, Home Economics, Greek literature and Physical Education. This programme has five sections: communication, relationships, making decisions, my body and contraception. It is mainly based on experiential learning activities, a change that is considered a huge improvement for the Ministry of Education and Culture. However, there is little evidence-based theory on certain matters, such as gender and culture. Also, the time is limited in discussing crucial issues, such as gender identity since all five sections have to be taught within 14 hours. Nevertheless, the quality and quantity of education primarily depends on the educator. As the whole attempt sounds an excellent idea, the qualifications, skills, abilities or experiences of the chosen educators to implement this particular programme need to be seriously considered. The educators not only need to be trained, but also feel comfortable in delivering such a programme.

The second proposed programme has a medical approach involving only Biologists. This programme has four sections that will be carried out within 15 hours. The sections are: male and female reproductive systems (including pregnancy and lactation) that consists of the 40% of the total teaching hours, pathologic conditions of the male and female reproductive systems, family planning (including STI's) and psychological health/sociology. As this is a medical oriented programme with limited discussion of socio-cultural factors on sexuality, arguably based on the evidence presented in the previous chapters, this approach it will probably be less successful. Even though will somehow increase knowledge, it is doubtful that will alter, shape or influence adolescents' attitudes and beliefs.

One may argue, whether the two programmes have been developed, adjusted or based on Cypriot culture and the needs of Cypriot adolescents. Both programmes were finally implemented in third school second grade. It is expected that after the pilot study, the whole idea and implementation of the

two programmes will be evaluated. The results will be essential for future decisions on sexuality education.

4) Mass Media

During the past decade a massive development of the Cypriot mass media has occurred. There are almost ten television channels and more than twenty radio stations. This is considered a large number for a small island with less than one million inhabitants. Most of the television stations are private, two are public and one is partially owned by the Church of Cyprus. So, the Cypriot viewer has a considerable choice about what to watch.

It is interesting to note that one owner or company has two or more mass media (e.g. television, radio station, newspaper etc.). Therefore, the same ideas and values are being promoted through more than one medium, with the potential of having a stronger effect on people. Despite that there are many channels, people rarely have the chance to watch programmes or listen to discussions/debates related to sexuality (e.g. homosexuality). Mass media can particularly influence young people whose values and attitudes are still being formed. Mass media is both a product of globalisation and a vehicle for the growth of globalization. Through the television, the internet, magazines, newspapers and so on, information about products, people, people's behaviours, events, music, sport, etc. are disseminated with incredible speed and particular 'spin' on almost every corner of the universe. Greek-Cypriot youth come to share the same taste in music as many other people from different countries; they wear the same brand of clothes as other young people from different countries; they learn about lifestyles in other countries which they want to imitate; they inevitably come to share the values of young people from different countries. Mass media is a potent vehicle for the development of universal values, of a universal culture and transnational identities (Korzenny, Ting-Toomey and Schiff, 1993).

At the same time, the Cypriot mass media is promoting the Cypriot culture, to those who are not Cypriots, highlighting what is unique to it, such as the

Cypriot hospitality and its expression in the friendliness of its people, the Cypriot love of life and having fun and how these are expressed in the various traditional festivals and various cultural events, the Cypriot cuisine and so on. The Cypriot mass media also contributes towards the maintenance of cultural traditions through documentaries, situation comedies, and serious drama programmes. There are also some current affairs programmes where social issues are occasionally discussed.

There are many Cypriot films, mainly comedies, underlying the role of genders within society. For example, 'Manolis and Katina' showing an irresponsible, not smart, chatty housewife, whereas the man is the breadwinner, reasonable and almost always in control of things. Furthermore, many channels when presenting the main news of the day have both genders as presenters, with the male being the main figure. Usually, young attractive women (with no special knowledge on the matter, meaning there are not meteorologists) present the 'weather', since it can be considered an easier task to do.

The assumption that media play a role in modifying human behaviour has intuitive and empirical roots (Korzenny, Ting-Toomey and Schiff, 1993). The fact that the message is mediated makes it impossible to gain immediate feedback of the results of the communication (Tones and Tilford, 1994). Some argue that direct persuasive power of mass media is limited and therefore, it is probably better not to be used alone in promoting health (Ewles and Simnett, 1992). Despite this, mass media can be very useful for drawing attention of the people and probably more effective when used with other strategies (particularly when taking culture in consideration) for the promotion of health. For example, AIDS messages need to be relevant to the culture they are directed to (Korzenny, Ting-Toomey and Schiff, 1993).
In Cyprus, the plethora of mass media acquired power, increasing the possibility of influencing the individual. For example, in a Cypriot study about

young people's (15-29 years) free time, 94% reported that they watch television often (daily-weekly), whilst only 37.5% reported that they read often (Cyprus Youth Organization, 1997). One can argue that within Cypriot culture mass media has a significant influence. The reason is because people (as previously mentioned) more or less know each other; the slightest event/news (usually presented bad news) that will be in the media everybody knows. This affects not only the individual involved and his/her immediate family, but his/her extended family too, because the reputation of the family will be distorted; and reputation is important for Cypriots.

Mass media are vital to the perpetuation of any new value system. Yet as the total system becomes unresponsive to human needs for individual freedom, expression and mutuality, people begin to challenge it and provide alternatives. After all, human ability to accept, reject and modify institutions in order to survive is almost limitless (Korzenny, Ting-Toomey and Schiff, 1993). Mass media are influenced by culture too. One example could be that, Cyprus television channels have not screened any condom commercial, whilst there are several campaigns related to drug misuse.

Summary

As ethnographic history is important to understand one's health behaviour, this chapter provided a historical and political perspective of Cyprus as well as it explored contemporary Cyprus in association with sexuality issues. The following chapter will discuss the methodology of this study as this was undertaken in Cyprus.

CHAPTER 6

METHODOLOGY

Introduction

"A scientific research method is a systematic approach to problem solving and to expansion of knowledge" (Polit and Hungler 1991:17). It involves the use of standards and procedures for demonstrating the 'empirical warrant' of its findings, purporting to show what is happening or has happened in the world (Cohen and Manion, 1994). It aims to develop and test theories or conceptual explorations of the relationships among the phenomena investigated (Polit and Hungler, 1991). The appropriateness of any research depends on the phenomenon under study: Its magnitude, the setting, the current state of theory and knowledge, the availability of valid measurement tools and the proposed uses of information to be gathered (McKinlay, 1992).

6.1 Study Design

A *survey* is "...designed to obtain information from populations regarding the prevalence, distribution and interrelations of variables within those populations" (Polit and Hungler, 1991:191).
A *Quantitative methodology* is used to test theories and hypotheses and to make generalizations that may contribute to the understanding of a condition or phenomenon and to the developing of a theory (Creswell, 1994).

The scope of this study was to investigate the knowledge, needs, attitudes and beliefs of the adolescents about sexuality matters and to explore the relationship between the cultural characteristics of Greek-Cypriot adolescents and sexuality.

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A *Qualitative research* study may have achieved a more in-depth understanding of the subjective perceptions of adolescents (Sarantakos 1993). Several practical constraints also ruled out the use of such an approach.

Firstly, the sensitivity of the subject under investigation (sexuality) would have made the recruitment of subjects (adolescents) almost impossible. It is debatable that permission would have been given by the Ministry of Education and Culture to enter schools in order to conduct in-depth interviews. Further, the headmaster/headmistress may also have objected to allowing their students to be interviewed in-depth on sexuality matters. Such gatekeepers are sensitive to public opinion and are well aware of the cultural constraints and controversy surrounding the topic. The School was considered as the most appropriate place to access subjects of similar age and with the same educational level. Secondly, for practical reasons the Ministry of Education and Culture as well as the teachers would only allow access to their students for a very short period of time and with the minimal disruption. Thirdly, since limited sexuality health research exist in Cyprus and taking in consideration the reservedness (as all of the above show) it was thought that it will be 'less threatening' and more acceptable for Cypriot people to start by gathering quantified baseline information and knowledge about the subject. Therefore, quantitative methodology with the use of a questionnaire was thought to be the most appropriate method for everyone-the students, the educators, the government and the parents.

6.2 Ethical Issues

The majority of education or health research involves human participants. It is the researcher's responsibility to treat participants with respect and dignity. The research proposal for this study was approved by the Middlesex University and a timetable was agreed (Appendix No.3). Since there is no national research committee in Cyprus, permission was sought through the Ministry of Education and Culture.

Initially, several meetings were held with the person responsible for health education in the Ministry of Education and Culture. The person in charge and a member of the health education team reviewed the questionnaire. When the permission to go ahead with the study was given, a personal meeting was held with the Head of the Secondary Education in the same Ministry, in order to discuss the administration of the questionnaire (see Appendix No.4 for the written permission given by the Cypriot Ministry of Education and Culture, for the implementation of this research). The headteacher of each school was informed about the purpose of the study as to give his/her permission, acting as *in loco parentis*. The relevant class-teacher from each school was also informed. Many of them asked to see the questionnaire before agreeing to its distribution.

As a result of various violations of human rights during the Second World War and following the Nuremberg Trials, the Nuremberg Code was produced. Its principles were later integrated in the 'Declaration of Helsinki' that was adopted in 1964 by the World Medical Assembly and revised in 1975. Another important code of ethics was produced by the 'National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research' in 1978 (commonly referred to as the Belmont report), following the exposure of the Tuskegee scandal in 1972. This involved an experiment, which began in the mid 1930s in the American town of Tuskegee; hundreds of African American men were denied treatment for syphilis in order to

observe the effects of the disease over a long period of time. Many professional organizations established their own specific codes of ethics such as the American Nurses Association in 1975, and the American Psychological Association in 1982.

The principles of Belmont report which were adopted for this study are:

The principle of Beneficence- involves the protection of subjects from physical, psychological harm, exploitation and the performance of some good. It is essential for any researcher to weight the cost and benefit of participation to individual subjects as well as the risks to the subjects against the potential benefits to society (Polit and Hungler, 1991). In this study, even though some of the questions were personal, the participants were assured of confidentiality. The review of the literature and the opinions of the panel of experts, regarding the questionnaire, helped the researcher to write personal questions in such a way as to avoid being insulting or provocative to anyone. Also, the researcher allowed time after the collection of the completed questionnaires to answer any of the students' questions that arose from the questionnaire.

The principle of Respect for Human Dignity- includes the right to self-determination, full disclosure and informed consent. The researcher gave verbal and written explanations to the subjects, emphasizing their voluntary participation in the study. A key element of informed consent is the participants inviolable right of withdrawal without any hindrance from the researcher (Dunn, 1999). The subjects were informed that they had the opportunity to withdraw from the research study at any time. However, completing and returning the questionnaire was taken as to indicate informed consent.

The principle of Justice- involves the right to fair treatment and privacy. The researcher set criteria for selecting the subjects (see section 6.3), ensuring their equal treatment at all times. The questionnaire included demographic data but it was anonymous. The researcher cannot link a questionnaire with a specific individual. Moreover, the questionnaires were safely stored by the researcher.

At the end of each class session (distribution, completion, collection of questionnaire and discussion) the researcher expressed appreciation for the subjects' participation and cooperation. This was also written on the cover page of the questionnaire. The sensitivity of the theme and the age of participants made the researcher more conscious in meticulously applying these principles.

6.3 Sampling

In Cyprus, there is public and private secondary education. *Public secondary education* is publicly funded and includes public general schools, public technical schools and public night schools. The public educational system is highly centralized with headmasters and teachers/educators appointed, transferred and promoted by the Educational Service Committee, an independent five-member body, appointed for a six year period by the President of the Republic. All public schools are under the supervision and responsibility of the Ministry of Education and Culture (Cyprus Statistical Service, 2000b). Students attend secondary education between the ages 12-18.

Public secondary general education schools consist of two cycles or stages. Stage I comprises of grades 1^{st}–3^{rd} (Gymnaesium) with emphasis on general core subjects, such as Greek Language and Literature, Mathematics, General Science etc, and the humanities. Stage II comprises of grades 4^{th}–6^{th} (Lyceum) with emphasis to subject specializations.

Private secondary education includes all private schools in Cyprus. They are owned and administered by private individuals or bodies but are liable to supervision by the Ministry of Education and Culture (Cyprus Statistical Service, 2000b). Students attend these secondary schools for seven years between the ages of 12-19.

Public technical schools were excluded from the study, since they begin after the completion of the 3^{rd} grade secondary school (continue from 4^{th}-6^{th} grade). The study was aiming at 3^{rd} grade students.

Public night schools were also excluded because the majority of the students are adults and not adolescents.

Private schools were also excluded from this study, since many of the students are not Greek-Cypriots and this research was aiming at this cultural group. They represent 10.1% of all students in secondary education.

The schools that participated in this study include only *public secondary general education (high) schools* in urban and rural areas of unoccupied (by Turkish troops) part of Cyprus, representing approximately the 89% of all students in secondary education within the Greek-Cypriot society. The target population was all 3rd grade secondary school students in public general education in Cyprus. The total number of 3rd grade students in public general education was 9.482. The accessible population consisted of a sample of the 3rd grade secondary school students in public general education from all five districts of unoccupied Cyprus.

There are several reasons for selecting this particular age group (13-14) of students:

- Education is mandatory in Cyprus up to 3rd grade, therefore they should have acquired at least basic information and knowledge related to health and sexuality.
-In 2nd grade students have Anthropology/Health Education class (that includes anatomy and physiology of the male and female reproductive systems), Home Economics class (that includes adolescence-related issues) and other independent lectures (e.g. by Health Visitors) regarding related matters such as HIV/AIDS. Thus, it is expected students to have some biological knowledge and some level of sexuality awareness.
-In 4th grade specialization begins for the students, thus such a class is likely to be more homogeneous. Also, these students are above the age of 14.
The data used to construct the sampling frame for the student population was taken from the Statistical Service of the Government of Cyprus for the

academic year 1998/1999. These were the latest published data (Statistics in Education, Cyprus Statistical Service, 2000b) at the time that this research was undertaken. To minimize error in the selection of schools the researcher used the 2001/2002 list of all schools from the Ministry of Education and Culture. The limitations that existed in this study – some of which have already been mentioned, the rest are listed below – meant that a simple random sample of students was not possible:

- The Ministry of Education and Culture gave the permission for this research with the agreement of minimal disturbance of the school system (e.g. teaching hours, students, educators).
- Considering Cypriot socio-cultural attitudes, the students could have perceived their selection negatively and that would affect the results of the study. Their main worry would have been 'why pick me and not someone else' having in mind the theme of the study (sexuality). As noted before, this was one of the first questions that the headteachers asked for their schools; they were assured that their schools were chosen at random and not because the researcher (or anyone else) had identified the existence of a problem.
- Students in all districts (that are not occupied by the Turkish troops) should be represented in the study because it was assumed by the researcher that there maybe sub-cultural differences between geographical areas. This was based on a variety of comments, impressions and feelings that Cypriot people have expressed through media, lay or professional discussions.

Due to the practical and resource constraints the cluster sampling method was used. **Cluster or Multi-stage sampling** is a commonly used procedure for large-scale surveys. The Nixon study (2000) that was comparing NHS with European standards and the National Opinion Research Center General Social Survey in 1988 (U.S.) are two of the educational and health research studies that cluster sampling and analysis were applied. Selecting a sample

from within a cluster can be performed by simple or stratified random sampling method (Polit and Hungler, 1995). Multistage sampling entails hierarchical groupings of units as the successive stages of sampling (Foreman, 1991).

Process of sampling

The following table summarizes the process of selecting the sample.

Table No.6.3.1: Sampling process

Stage 1: list of all schools by district and urban/rural areas
Stage 2: randomly select schools within each district and urban/rural areas (stratify)
Stage 3: random selection of classes within each selected school
Stage 4: all students in each selected class participated in the study

A list of all schools by district and urban/rural areas for all Cyprus was obtained from the Ministry of Education and Culture. The number of schools that were selected from each of the five districts and urban/rural areas was proportional to the Pan-Cyprian number of students and schools in each district and urban/rural areas. This was done to improve the representativeness of the sample. A specified number of units from each group or stratum (e.g. urban) can be selected (Babbie, 1990).

All secondary schools had the same opportunity to be included in this research. This method is not subject to any biases of the researcher (Polit and Hungler, 1991). All secondary schools were put in the computer according to their district and rural/urban status and then some numbers were randomly selected. They were arranged in number tables (each school had a

number) as to be in a computer-readable form. Then, the computer automatically selected the sample at random.

All secondary schools offered 1st cycle education, meaning grades 1st, 2nd and 3rd. Twenty-seven (27) schools were selected, almost 50% of all public secondary schools in general education.

The size of the school could not be controlled in this study. The total number of 3rd grade students in the participated schools ranged from 105-275.

In each school all third grade classes were numbered consecutively, then they were put into a box and a number was drawn from the box, selecting one class at random. The questionnaire was distributed to all students of the selected classes.

The table below shows the total student population in each district and urban/rural areas and the total number of schools; and the number of selected schools.

Table No.6.3.2: Population and selection of sample

Districts	**No. of schools Urban/Rural**	**No. of students Urban/ Rural**	**% of students**	**No.of selected schools Urban/Rural**
Nicosia	17/ 6 = 23	3140+637= 3775	40%	8 / 3
Limassol	12 / 5 = 17	2408 + 265= 2673	28%	6 / 1
Larnaca	6 / 6 = 12	1265 + 438= 1703	18%	3 / 2
Paphos	5 / 4 = 9	790 + 120= 910	10%	2 / 1
Famagusta	* / 2 = 2	- + 420= 420	4%	* / 1
TOTAL	63	9482	100%	27

*95% of Famagusta is occupied by the Turkish troops and the remaining 5% is considered as rural area.

The above data (as previously mentioned) were based on the formal data given from the Statistical Service (in Statistics in Education, Cyprus Statistical Service, 2000b) and on the catalogue of the public general schools of secondary education by district 2001-2002 from the Ministry of Education and Culture.

The researcher was aware of the possibility that the above data might have changed since their publication. Therefore, each participating school was asked to give the current number of their students in 3rd grade, as to identify any significant changes. Accordingly, no major fluctuations were noted in students' numbers.

Calculating the sample size

The sample size was calculated using the following formula given by Collins (1986:108):

Table No.6.3.3: Calculation of sample size

$$n = \frac{K^2\, DF^2\, p(100-p)}{L^2}$$

K= Standard error multiplier for required confidence level = 95% = 2, 90% =1
DF= Design Factor associated with particular design (e.g. cluster correlation multiplier)
L= Permitted distance between p and each confidence limit (the margin of error)
p= Estimate of sample having target characteristic (% who agree or disagree)

K= 1 for Confidence level = 90% (see page 172)

DF= 1.84 This was based on average of 25 questionnaires per class and the uncertainty of homogeneity level of each class (see page 172)

L= 5 (margin of error)

p= 70 Based on the data from the pilot studies there was 70%/30% variability on the students' responses. Thus, 70% was considered as the estimate of sample having the target characteristic

Multipliers for Cluster Correlation (Design Factor)

Formula = $\sqrt{[1+p(b-1)]}$ (where p=ICC and b = no. of interviews in each area)

p= 0.02 - 20 Interviews = Multiplier = 1.2
- 30 Interviews = Multiplier = 1.25

p= 0.1 -20 Interviews = Multiplier = 1.7
-30 Interviews = Multiplier = 2.0

$$DF = \sqrt{[1+0.1(25-1)]} = \sqrt{[1+2.4]} = \sqrt{3.4} = 1.84$$

$$n = \frac{1^2+(1.84)^2\, 70(100-70)}{5^2} = \frac{7108.5}{25} = 568$$

(Collins, 1986:99)

Cluster sampling tends to have more sampling errors than simple or stratified random sampling (Collins, 1986). These are corrected by 'inflating' the sample size to account correct for the homogeneity of the groups. Collin's calculation of sample size was used, adjusting its parameters such as design factor, inter-cluster correlation coefficient as to minimize sampling errors. In addition, more students were recruited than the calculated number (see Table No.6.3.3).

Inter-cluster correlation coefficient (p) is an estimate of the degree of homogeneity of cluster members (Collins, 1986). Since this study uses cluster sampling, the population is less representative than random selection. If for a household (in this case schools) the range of p=0.2 and the minimum p=0.02 (Collins, 1986), then in this study p=0.1 was adopted as the best possible value for these clusters (classes). The average class size in Cyprus is 25, thus indicating the number of interviews in each cluster. Based on these data a multiplier of 1.84 was calculated.

The above calculation indicated a sample size of Boys= 284 and Girls= 284, N=584 would produce point sample estimates with a 90% level of confidence and 5% margin of error when applied to the wider population. This implies that there is a 90% possibility that the true mean of the population is within +/- 5% of the point sample estimate. However, samples tend to be more accurate than theory suggests; the population value is always likely to lie towards the center of the interval (Collins, 1986).

The researcher added some extra questionnaires to counteract any non-response (e.g. absence from school). Therefore, **697** questionnaires were distributed. In order to maximize the response rate, all questionnaires were distributed by the researcher herself, who was also present at all times and responded to any questions of the students. The response rate was 100% (334 boys and 363 girls= 697).

6.4 Data Collection

The choice of data collection mode is directly related to the sample frame, research topic, characteristics of the sample and available facilities (Fowler, 1993).

According to Judd et al. (1991), *structured questionnaires* have several advantages: lower cost over personal interviews, avoidance of interviewer bias, the respondents feel less pressure for their immediate response on the subject, and questionnaires give the respondents a greater feeling of anonymity and thus encourage them to be more open in sensitive questions. Participants may feel more comfortable or less threatened in responding to a questionnaire because along with anonymity, it assures confidentiality too. There is evidence of greater willingness to report sensitive behaviours on self-administered questionnaires than face-to-face interviews (Wellings et al., 1994). In addition, using a structured questionnaire all subjects have to respond to the same questions with the same choices.
Structured questionnaires have disadvantages too, such as lower response rate, lack of control over question order, inability to correct any misunderstandings or answer questions. Sometimes subjects respond according to what they perceive is the 'correct' answer.

In order to compensate for some of the disadvantages identified in the literature the researcher took the following additional actions:

- To achieve a high response rate the researcher personally distributed the questionnaires, provided instructions and waited until they were completed by those who wished to complete them and then collected all questionnaires.

- To resolve and/or minimize misunderstandings and achieve uniformity the researcher distributed all the questionnaires to each class. She provided the same instructions to all subjects and answered their queries prior, during and after the completion of the questionnaire.

6.4.1 The Instrument

A research study instrument design has two components: deciding what to measure, and designing and testing questions that will be good measures (Fowler, 1993). The research instrument for this study was based on the instruments of previous research studies. Some questions were used in their original form, others were modified and some new questions were created. Two of the instruments were previously used in Cyprus and one in Germany:

-Freie University of Berlin, (1997). *Sex education for, by and with young people.*

This study included a great variety of questions related to sexuality issues that gave the researcher a very broad perspective and a useful tool in investigating this matter.

-Veresies K. and Pavlakis A., (1996). *High school students and psychoactive substances* (in Cyprus). Egefalos , Vol.33: 39-45.

-Cyprus Youth Organization, (1997). *The free time of young people in Cyprus.* Nicosia : Cyprus Youth Organization

The choice of these questionnaires was based on the following rationale: It was important (for this study) to use Greek-Cypriot questionnaires, since they may reflect more accurately local cultural issues regarding adolescents and/or sexuality. Both Greek- Cypriot questionnaires included questions on sexuality matters. However, their primary aim was not adolescent sexuality.
Since limited research exists in this field in Cyprus, it was thought as appropriate to use a questionnaire from another country, more experienced in

research and adolescent sexuality issues. After reviewing several questionnaires, the above German questionnaire was thought to be meeting the needs of this study and used as it was designed for young people, having sexuality as its main theme.

Although the initial intention was to use one of these questionnaires, during the process of refining the purpose of the study the researcher abandoned this idea. The main reason was that the researcher wanted to investigate the impact of culture and gender on attitudes and knowledge of Greek-Cypriot adolescents regarding sexuality and identify their needs and none of these questionnaires were meeting the aims of the study. Therefore, an eclectic approach was adopted and a new questionnaire was created. Although this can be considered as a limitation for the study it was thought to be important, to meet the objectives and the purpose of this study. As previously mentioned, some questions were selected from each questionnaire (mainly from the Freie one). New questions were added in part II, section III (attitudes and beliefs) on religion and gender roles, and on part II, section II (resources and needs) on school books and the subjects' need for more information stating a specific topic. The added questions came from the need to investigate as much as possible the impact of Cypriot culture on adolescent sexuality. The researcher informed the authors of these studies about the present study and gained their consent regarding the use of some questions from their instruments.

The questionnaire for this study was written in the Greek language. The Freie questionnaire was in German, so it was translated from German to Greek by one person (professional in the business and tourist industry) and another person (a medical doctor) did the back-translation from Greek to German in order to validate the German to Greek translation. Both individuals read, write and speak fluently German and Greek. Also, it was necessary for this study to be translated in English as to be evaluated by the examiners. For ensuring

the best translation in English two professionals were asked to offer their opinion. One secondary school teacher for English language reviewed the translation from Greek to English and a secondary school psychology teacher-counselor (who speaks, reads and writes English fluently) performed the back-translation from English to Greek.

The construction of the final version of the questionnaire was reviewed by a panel of experts. This included a:

- Senior Medical Officer at the Ministry of Health and National AIDS Programme Manager and Epidemiologist
- Medical Officer at the Ministry of Health and AIDS Health Education Programme Officer
- Senior Programme Officer at the Cyprus Family Planning Association
- Lecturer in Health Education in Tertiary Education (who holds a PhD in Health Education) and
- Researcher with experience on Cyprus youth research.

The researcher had separate meetings and discussions with each expert as to discuss the questionnaire. The two medical doctors were seen together. The questionnaire was reviewed for its content, language and presentation. The comments were useful and encouraging and some changes were made, mainly regarding the use of language. However, there is no completely objective method of assuring content validity. It is mainly based on judgment (Polit and Hungler, 1991). The questionnaire was also reviewed by two representatives of the Ministry of Education and Culture that had the responsibility of the approval of this study.

Any written information should be assessed for its readability. It cannot be assumed that each subject will be able to understand every question, especially in this case that young students were the potential subjects. Also, some terminology that was used might not have been understandable by the

particular subjects. There are recognized methods for measuring readability such as the Flesch Formula and the Gunning's Fog Formula, that are available on computer software programmes. These scales range from *very difficult* (0-30), *difficult* (31-50, *fairly difficult* (51-60), *standard* (61-70), *fairly easy* (71-80), *easy* (81-90) and *very easy* (91-100) (Hughes and Foster in Foster, 1994). The readability score for the questionnaire used, on the Flesch scale, was 64.1- *standard*.

The questionnaire consisted of two parts. The first part consisted of socio-demographic questions. The second part consisted of questions intended to assess three domains: The first domain was designed to assess students' knowledge for sexual and reproductive health. The second domain contained questions designed to assess students' knowledge and use of resources about sexuality issues. The third domain contained questions designed to assess students' attitudes and beliefs related to sexuality issues.
All questions were close-ended. In section III, part II (attitudes and beliefs) a Likert-scale was used for student responses. It is possible to measure attitudes with the use of the Likert-scale. It emphasizes the evaluative feature of attitudes, but the evaluations are inferred from people's ratings, based on their knowledge and feelings about the particular theme under investigation. The questionnaire consisted of 10 pages, included a cover page (Appendices No.5a and 5b) and took approximately 20-30 minutes to complete.

6.4.2 Data Collection Procedure

All headteachers of selected schools were informed about the study by phone or in person by the researcher. The purpose of the research was explained to them and a date for the distribution of the questionnaire was agreed. A reminder letter was sent to each headteacher (Appendix No.6). Following this,

a copy of the Ministry of Education and Culture approval of the study and a copy of a brief statement of the purpose and objectives of the research study was given to the headteachers (Appendix No.7). Some of them asked for a copy of the questionnaire and this was provided to them. The distribution and collection of the questionnaires were carried out between 10/12–21/12/2001. There was also a back up week between 7/1–1/1/2002. There were a few changes on appointments but always within the above time frame. In one school the questionnaire was distributed on the 6/12/2001 and another one in 8/1/2002 as the schools programmes allowed.

An effort was made to ensure that classroom conditions during the time of data distribution and collection were similar, thus the researcher was present at all times. The potential respondents were told the purpose of the study, assured of anonymity and confidentiality, reminded of their option to withdraw, informed that the results will be sent to the headteacher, were given instructions for completion of the questionnaire and thanked for their participation. After the completion and collection of the questionnaire, a few minutes were set aside to answer any queries. A questionnaire field note (Appendix No.8) was completed by the researcher for each class, as to help the analysis of the data as well as to provide further information about each class. Each session (instructions, distribution, collection, discussion) lasted 40-50 minutes.

After the completion of all data collection a thank-you letter was sent to all headteachers reminding them that the Ministry of Education and Culture will receive a copy of the study when completed and that they receive the study's executive summary (Appendix No.9).

6.4.3 Pilot Studies

The piloting process consisted of two pilot studies with the use of the Greek version of the questionnaire. This was done to identify potential problems with the questionnaire (e.g. unclear questions), the actual time required to complete the questionnaire and to calculate the resources needed and the cost to administer, analyze and report the main study. Further, pilot studies test the reliability of the instruments. The purpose of the pilot study is to try out the instruments and to test the feasibility of the data collection process (Reid and Boore, 1987). The pilot study may reveal that revisions are needed (Polit and Hungler, 1991).

The *first pilot study* included 11 subjects. The participants were selected from a scouts centre in the urban area of Nicosia. At the scouts centre 30 young males and females were present. Each scout was given a number and then all numbers were put in a box and 11 numbers (representing scouts) were selected at random. 1 subject was excluded because she was under the age considered for this particular study. The 10 remaining subjects (8 boys and 2 girls) were all at the age of 14-15 years of age. It was explained to them from the beginning (before and after selection) that participation was voluntary. The researcher was present during the whole process (instructions, selection, distribution, collection). The return rate was 100%. Answering the questionnaire took the participants approximately 15-18 minutes.

A second pilot study was carried out in a school setting. The second pilot was done in a secondary school that was not included within the (randomly) selected schools. Twenty-two 3rd grade secondary school students (11 boys and 11 girls) participated in both test and retest. The questionnaire was administered twice to assess the test-retest reliability. Reliability refers to the stability or consistency of a measure. Test-retest is an especially useful measure of consistency (Dunn, 1999). The students were given the same

questionnaire to complete with four days difference. The test-retest score was r=0.75, which is considered satisfactory. This was estimated by the correlation between the two scores obtained (test-retest) (Polit and Hungler, 1991 ; The Open University, 1979). There were no important changes in students' responses on the retest. Some differences were recorded in the knowledge section (part II, section I). For example in question no. 4:

Table No.6.4.1: The HIV/AIDS virus is not transmitted by mosquitoes (KQ4)

	Test	Retest
Base:	22	22
Yes	6	10
No	12	9
Do not know	4	3

The changes of the responses in this case could be because the responders have asked or learned the correct answer either by looking it up in their anthropology/biology books, ask their teacher or any other way.

The short period between test and retest might be a methodological limitation: It could have made the participants to find the procedure boring, remember some of their answers (from the first test) or answer superficially the questionnaire. This may minimize the possibility of modification of any question in the particular questionnaire and therefore alter the results. It could be argued, that even a period of two-three weeks, between test and re-test, could have given the same results. However, the memory could have been weaker.

After the retest there was a discussion with the students regarding their understanding of the questions, instructions and the presentation of the questionnaire. All inquires of the students were related to knowledge.

When attitudes, feelings or opinions are asked there is no objective way of validating the answers (Fowler, 1993). However, this does not mean that validation is meaningless. Validity can be assessed by the correlations with other answers in different questions that the responder has provided in the questionnaire or other facts about the respondent's life that one thinks that may be related to what is being measured. The meaning of answers must be inferred from patterns of association (Fowler, 1993). In this study, content validity was assured with the use of the experts in the fields of health, health education and/or sexuality, as previously mentioned, in reviewing the questionnaire. However, there are no completely objective methods of assuring the adequate content coverage of an instrument (Polit and Hungler, 1991).

All participants in the pilot studies and test-retest had similar characteristics with the subjects of the main study. Both groups were excluded from the main study. Findings indicated that there were no major problems with the instrument. The words used were clear and there was no confusion with the structure of the questionnaire (e.g. boxes, codes presented on it). It was suggested to improve the presentation of the questionnaire. The researcher added the snowman figure at the last page of the questionnaire (since the main study was going to take place at end of December) and the Middlesex University logo to improve its professional presentation. The pilot studies helped the researcher to form the set of instructions (for the students) that was used during the main study.

6.5 Analysis of the Data

After data collection, all questionnaires were checked by two persons (the researcher and a statistician) and then put into the computer for the analysis of the data. When analyzing the data it is important to follow a data analysis strategy as to provide the best possible results with accuracy and efficiency. Altman (1991) suggested the following strategy that the researcher adopted in this study:

1. Data collection
2. Data entry
3. Data checking
4. Data screening
5. Data analysis
6. Checking results
7. Interpretation

Data collection was done by the researcher herself. During the collection of data (in the classroom) the researcher was checking if all questions were answered and if all responses were clearly indicated (e.g. putting a circle). Questionnaires were checked again, in more detail, by the researcher and a statistician to ease entering the data. Since the questionnaire was pre-coded, no major difficulties were recorded during *data entry* to the data file.

Data cleaning or checking and Data screening

Data cleaning or checking is an essential part of data processing. Data were checked for errors in coding and/or data entry, using paired checking, inter-item consistency and checking for outliers. A check was done for outliers, involving the check of frequency counts associated with every value for every variable, since missing values or outliers often may cause difficulties in cluster analysis (Godehardt, 1990). Then, consistency checks were performed which focus on internal data consistencies; data in one part of the questionnaire

were checked if they were compatible with data in another part of the questionnaire.

Data analysis

The data was analyzed with the use of the Statistical Package for Social Sciences software (SPSS) Version 10. It is one of the most widely used statistical software packages. Descriptive and inferential statistics were used to describe, synthesize and draw conclusions. Descriptive statistics is a method of presenting quantitative descriptions in a manageable form. They can describe single variables or associations that connect one variable with another (Babbie, 1990).

The purpose of the analysis was to:

- Present the results from the sample and estimates for the wider population;
- Explore variations in the results by gender and area of residence;
- Explore patterns of relationships between variables.

Several statistical tests were performed as to meet the above purposes; some of these are described below.

Tests of significance are used to establish whether certain inferences can be made, and if so, with what probability of being correct. Non-parametric techniques such as Chi-square are often appropriate and recommended for health surveys. For example, survey data being mostly discrete variables and often measured by ranking scales are not normally distributed and thus a non-parametric test can be an appropriate technique to use (Reid and Boore, 1987).

An estimation rather than hypothesis testing approach was used. The confidence interval indicates the range of values in which the population

value is estimated to lie (Altman, 1991). Researchers conventionally use either a 95% or a 99% confidence interval (Gravetter and Wallnaw, 1992 ; Polit and Hungler, 1991).

Phi coefficient is an index of describing the relationship between two dichotomous variables. It is interpreted as a measure of association and allows one to interpret the strength of a relationship (Munro, 2001).

Factor and Cluster analysis

Factor analysis was carried out for questions on attitudes and beliefs (part II, section III). Factor analysis is a multivariate statistical method and it is used for:

- Revealing patterns of interrelationships among variables;
- Detecting clusters of variables, each of which contains variables that are strongly intercorrelated and hence somewhat redundant;
- Reducing a large number of variables into a smaller more manageable set of measures.

(Agresti and Finlay, 1997 ; Polit and Hungler, 1991)

Factor analysis is a useful tool in understanding data but does not have any readymade solutions. In factor analysis the number of the factors or the complexity of the variables can be a limitation. The researcher can select to observe for each factor five or six variables. Different researchers may read different concepts into items though (Polit and Hungler, 1991). The complexity is indicated by the number of factors with which a variable correlates. Estimating the complexity of the variables is part of generating hypotheses about factors and selecting variables to measure them (Tabachnick and Fidell, 1996). The essential purpose of factor analysis is to identify (if possible) the covariance relationships between variables, in terms of few underlying but unobservable factors (Johnson and Wichern, 1998).

Thus, as mentioned above, factor analysis has considerable utility in reducing numerous variables down to a fewer and more manageable set of measures. This eases the description and interpretation of data.

In this study factor analysis was performed on attitudes and beliefs questions (section III, questions18-38) and so it was run on 23 variables. Factors are usually taken to be underlying traits, attitudes and/or beliefs that are reflected in specific rating questions. The number of factors were chosen with the use of some technical aids, such as eigenvalues and the percentage of variance accounted for. However, these are guides and not absolute criteria. Moreover, an extraction method was used based on the nature of the variance in the data. In this case the *principal components method* was applied. Principal components method is based on the assumption that all measurement error is random and the mean of deviations is zero. The goal is to convert a set of variables into a new set of variables that is an exact mathematical transformation of the original data (Munro, 2001). Then, *factor varimax rotation* was applied. This tends to produce factors that have low loadings with some variables and high loadings with other variables (Munro, 2001). Varimax rotation was used for easier interpretation of the components.

The most widely used guideline for choosing the number of factors is to stop factoring when eigenvalue for a factor falls below 1. Initially, the communalities were 1. They are of interest when the solution is reached (are below 1) and measure the percentage of variance in each variable that is accounted for by the selected number of components. Communality may indicate where to include or exclude a particular variable for factoring. In this study there were 9 eigenvalues over 1. Nine components were selected and they collectively account for about 58% of the variance of the 23 variables. This was not very clear because one eigenvalue is barely above 1 (1.013) and the next largest is barely below 1 (0.963). So, another solution was tried with different number of factors. Finally, four factors were identified: a) knowledge, b) resources (e.g. parents, school), c) needs and d)

attitudes/beliefs, church/religion influences (e.g. marriage) regarding sexuality issues. The researcher gave these labels based on the items correlations in each factor on the varimax rotated matrix.

Cluster analysis is a method of exploring data aiming to generate theories based on possible relationships among data (Denis, 1999). Even though cluster analysis is not widely used in health and educational research, in this study it offers the opportunity to identify any associations between cultural attributes and beliefs related to sexuality issues. Cluster analysis is typically used for exploration of data and tasks suitable to cluster analysis include:

- finding a typology
- model fitting
- prediction based on groups
- hypothesis testing
- hypothesis generation
- data reduction

(Denis 1999:160)

It was decided to apply cluster analysis for acquiring more objective associations between variables. In this study, *cluster* is considered a subgroup of the sample with similar characteristics based on the four factors that were identified. These characteristics were considered as priority to meet the objectives of the study.

The basic objective in cluster analysis is to discover natural groupings of the items (Johnson and Wichern, 1998). Grouping should be done on the bases of similarities or dissimilarities of the items.

In cluster analysis individuals that are close to each other based the *metric* (a method of determining how close two individuals are) are said to be in the same group. The grouping in this research study was a non-hierarchical (simple) clustering called **K-Means**. It is a useful technique when the sample is over 200. One states the number of clusters that one thinks are

appropriate, and the required number of clusters will be created. This technique can be applied with the use of the SPSS (Denis, 1999). The K-Means cluster analysis is efficient because it does not compute the distances between all pairs of cases (in this study there were 697 valid cases), as do many clustering algorithms, including those used by the hierarchical clustering methods. The K-Means cluster analysis attempts to identify relatively homogenous groups of cases based on selected characteristics, while hierarchical cluster attempts to identify relatively homogenous groups of cases (or variables) in a separate cluster and combines clusters until only one is left. When employing K-means method several trials are performed, each with a different number of clusters and compare the results using criteria such as separation, number of observations per cluster, pattern of means and validation, in order to decide on the final solution. In an attempt to describe the clusters, the patterns of means were also analysed. Thus, the group means were computed on the cluster variables. This is an important step in understanding and naming the clusters.

Cluster analysis provides useful hints to the interpretation of the outlined clusters; therefore, it serves as a kind of validation. This is superior to factor analysis (Godehardt, 1990).

In this study, cluster analysis was based on the four factors that were identified by the factor analysis. Cluster analysis indicated four different segment groups of responses (see chapters 7 and 8), meaning that each cluster was characterized by a particular pattern of response on the four underlying factors. Each group was described in terms of its demographics, knowledge, resources and cultural characteristics (see chapters 7 and 8).

Check results

Results were somehow as expected and there was no need to check for any further error of the data.

The *interpretation* of the research findings represents the researcher's attempt to understand research results (Polit and Hungler, 1991). Accuracy of the analysis is one important factor for a proper interpretation of the results.

The limitation of this study in terms of the use of cluster analysis after factor analysis, is that clustering of factors scores looses some of the richness of the original data (the components did not account for 100% of the variance of the variables). However, it does reduce the scope of the interpretation and avoids problem of weighting some issues more heavily than others due to the number of questions per issue.

Summary

This chapter has discussed in detail the rationale of the study design and explained the methodology undertaken for this research study. Quantitative methodology with the use of a questionnaire was applied; and with cluster sampling stratified by urban/rural location and district. The next chapter will describe the findings of this study.

CHAPTER 7

FINDINGS

Introduction

In this chapter the findings of the study are presented. The chapter consists of five sections. The first section includes the socio-demographic characteristics, sections two to four presents the analyses of participants' responses regarding their knowledge on sexual and reproductive health, their resources and needs; and their attitudes and beliefs in relation to sexuality issues. In section four the findings are presented under four main areas: Gender and family roles, gender and sexual roles, gender and sexual relationships and views for education about sexuality. Section five discusses cluster analysis results. All participants responded to all the questions of the questionnaire.

7.1 Characteristics of the Sample

Tables No.7.1.1 provides a summary of the characteristics of the sample by age and gender. The sample consisted of 48% (n=334) boys and 52% (n=363) girls. The majority (67%, n=464) were 14 years of age. There was an even distribution of the subjects by age in each district and urban/rural area.

Seven percent (7%, n=48) of the participants were 15-16 years old. These are probably students that had to repeat the same grade at some point of their schooling. This is confirmed with the question 'if they ever had to repeat the same grade' where 5% responded positively. Another reason could be that the remainder was probably recent immigrants and who moved had to repeat a class so as to catch up with the classes especially in Greek language.

Table No.7.1.1: Sample by gender (D2)

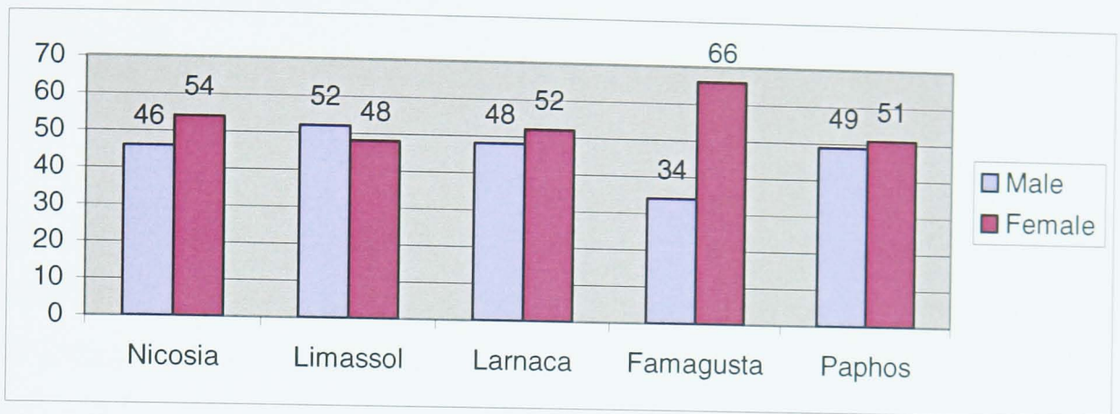
		GENDER	
	Total	**Male**	**Female**
		(a)	(b)
Base:	697	334	363
12	2	1	1
	*	*	*
95% CI	-	-	-
13	183	87	96
	26%	26%	26%
95%CI	23-29	21-31	21-30
14	464	216	248
	67%	65%	68%
95%CI	63-70	60-70	63-73
15	43	25	18
	6%	8%	6%
95%CI	4-8	5-11	4-8
16	5	5	-
	1%	1%b	-
95%CI	0.3-2	0-2	-
Total	697	334	363
	100%	100%	100%

Statistically Significant ($p<0.05$) – a/b
*small base

There was almost an even distribution between subjects living in urban and rural areas and by gender. Of the total sample, 53% (n=371, males=178, females=193) were living in urban and 47% (n=326, males=156, females=170) in rural areas.

The distribution of the subjects in each district by gender was also almost even, except Famagusta where more females were recruited than males (Figure No.7.1.1). This may be because boys in rural areas tend to leave or drop out of school at a younger age (Cyprus Statistical Service, 2000).

Figure No.7.1.1: Gender by district
(D1)



Tables No.7.1.2a and b summarize the characteristics of the sample family living arrangements. Ninety percent (90%, n=626) were living with both of their parents. A significantly higher percentage of Famagusta participants reported living only with their mother. This will be discussed in chapter eight.

Table No.7.1.2a: Whom you are living with now
(D3)

	Total	95% CI
Mother and father	626	
	90%	88-92
Only with mother	45	
	6%	4-8
Other	26	
	4%	2-5
Total	697	
	100%	

Table No.7.1.2b: Living with mother only. Famagusta compared with the other districts

	A. Famagusta %	B. Non Famagusta %	A-B	95% CI for A-B	X^2, p value
Only with mother	n=7 20%	n=38 6%	14	1-27	X^2= 11.192 p<0.05

The majority of the respondents have one or two siblings (72%, n= 502) (Table No.7.1.3a). A significantly higher proportion of students in Famagusta and Larnaca came from larger families, having three and more siblings (Table No.7.1.3b).

Table No.7.1.3a: Siblings (D4)

	Total	95% CI
0	49	
	7%	5-9
1	279	
	40%	36-44
2	223	
	32%	28-35
3 +	146	
	21%	18-24
Total	697	
	100%	

Table No.7.1.3b: Siblings. Famagusta and Larnaca compared to the other districts

	X. % >3 Siblings	Y. % >3 Siblings (not A)	X-Y	95% CI	p value
A1. Famagusta	n=12 34%	n=134 20%	14	2-30	p<0.001
A2. Larnaca	n=40 34%	n=106 18%	16	6-24	p<0.001

At this point it is important to mention that, in Cyprus, gymnasium includes secondary school grades 1st-3rd and its attendance is mandatory. Lyceum includes secondary school grades 4th-6th. Figures No.7.1.2a and b summarize the educational background of the participants' mothers and fathers. Thirty-five percent (35%, n=247) of the participants' mothers had graduated from an elementary school or a gymnasium (secondary school). Twenty-seven percent (27%, n= 186) of them had finished a tertiary school or a university. As far as the fathers of the participants are concerned, 35% (n=241) of them had graduated from an elementary school or a gymnasium. Thirty percent (30%, n=210) of them had finished a tertiary school (e.g. Nursing School, Paedagogical Institute, Higher Institute of Technology, Police Academy, private colleges) or a University.

A higher percentage of parents from urban areas (mothers: 20%, n=75; fathers: 29%, n=106) have further/higher education compared to parents from rural areas (mothers: 8%, n=27; fathers: 9%, n=29). This was found to be statistically significant (X^2=61.455 for mothers; X^2=65.533 for fathers, p<0.001). This will be explored in the following chapter.

Figure No.7.1.2a: Educational level of the mother (D8)

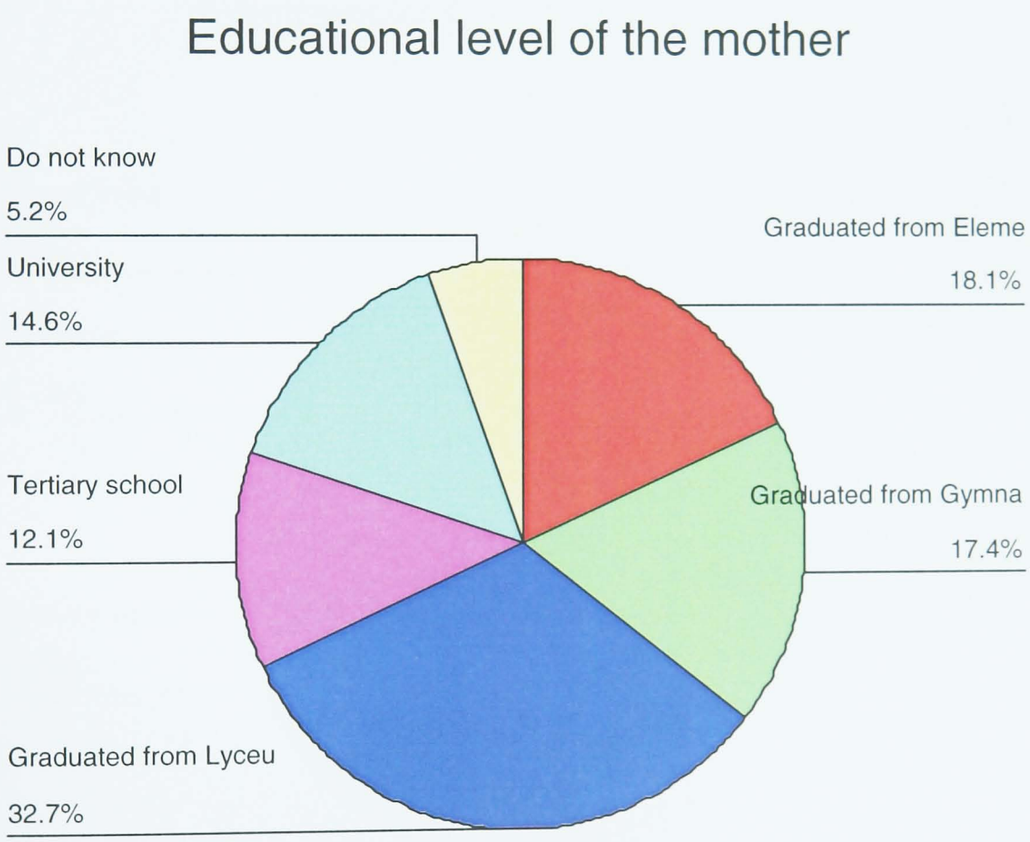
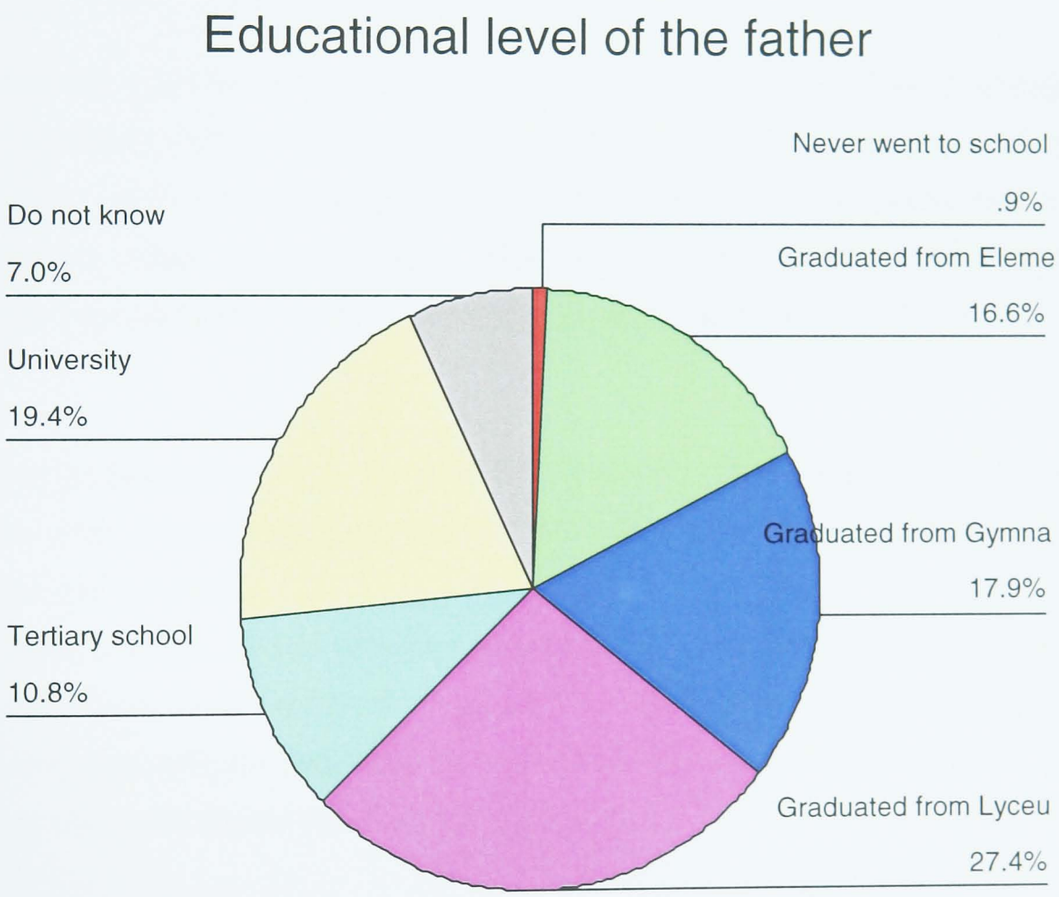


Figure No.7.1.2b: Educational level of the father (D9)



Educational performance of students

Ninety-five percent of the respondents (95%, n=660) never had to repeat the same grade, meaning that they successfully passed up to the third secondary school grade. There was little variation between urban/rural and districts.

Participants' religious background

The vast majority of the participants (98%, n=683) were Christian Orthodox. One percent (1%, n=4) Maronites, 1% (n=5) Jehovah's Witness and 1% other religion (n=5) were reported. No difference was reported between males and females, urban and rural areas. Moreover, in Famagusta, 3% of Maronites were reported while in other districts the percentage was 0%-1%.

Ninety-seven percent (97%, n=681) of the respondents reported that religion was very or somehow important to them and 3% (n=16) reported that it is not important to them.
Similar findings as the previous question were reported and in the question 'how important is religion in your family'. Ninety-nine percent (99%, n=691) stated that religion was very or somewhat important to their families, while only 1% (n=6) stated that it was not important.

Despite the majority of the participants reported that religion was important to them and their families, most of them do not attend church very often (Table No.7.1.4). It can be argued that participants feel 'religious' and believe in Christianity, however they do not find that necessarily should regularly attend church. Another argument could be that the students have internalized a value system that says they 'should' be religious, but in reality they are not. This provides evidence of enduring cultural relevance of religion in Cyprus.

Table No.7.1.4: How often do you go to church by gender (D12)

		GENDER	
	Total	**Male**	**Female**
		(a)	(b)
Base:	697	334	363
Weekly	132	67	65
	19%	20%	18%
95% CI	16-22	16-24	14-22
Monthly	288	123	165
	41%	37%	45%a
95% CI	37-45	32-42	40-50
Infrequently/ Never	277	144	133
	40%	43%	37%
95% CI	36-44	38-48	32-42
Total	697	334	363
	100%	100%	100%

Statistically Significant ($p<0.05$)– a/b

7.2 Knowledge/Education related to Sexual and Reproductive Health

The knowledge section included eleven questions. These were grouped together according to their topic/theme, such as HIV/ STI's, forming three subscales. This was done for the purpose of the analysis to have a clearer understanding of participants' responses. The three subscales are:

a) HIV/AIDS, STI's

It included the following questions:

- HIV/AIDS can not be transmitted by hugging or shaking hands (Q2)
- The HIV/AIDS can be transmitted with male-female contact (Q3)
- The HIV/AIDS virus is not transmitted by mosquitoes (Q4)
- You can not understand a person from his/her appearance if he/she has any sexually transmitted disease (Q5)
- The contraceptive pill does not protect you from a S.T.I. (Q6)
- The male condom is one of the safest preventative measures against STI's (Q7)

b) Conception

It included the following questions:

- The fertilization of the ovum takes place in the... (Q1)
- It is possible for a woman to become pregnant during the first sexual intercourse (Q8)
- There is a chance for a woman to become pregnant if she has sexual intercourse during her menstrual period (Q9)

c) Alcohol, narcotics

It included the following questions:

- Three pints of beer may alternate a person's behaviour (Q10)
- The use of narcotic drugs has no effect on someone's health (Q11)

The students' scores suggest that participants have better objective knowledge on alcohol and narcotics (82%), some knowledge on HIV/AIDS, STI's (61%) and limited knowledge on matters related to conception (41%). These mean scores along the standard deviation (SD) are shown in Table No.7.2.1. The range of scores was from 0-100 since some of the participants answered all knowledge questions and some none of them correctly.

Table No.7.2.1: Knowledge scores

Groups	**Range**	**Mean**	**SD**	**95% CI**
HIV/AIDS, STI's	0-100	61%	20.5	58-60
Conception	0-100	41%	26	59-62
Alcohol, narcotics	0-100	82%	26	39-43
Total	0-100	59%	15.5	80-84

Overall, both genders seemed to have a similar degree of knowledge on sexuality matters, whilst males have significantly better knowledge about HIV/AIDS, STI's issues (Table No.7.2.2).

Table No.7.2.2: Variations in knowledge scores, by gender

Groups	A. Male % Mean score SD	B. Female % Mean score SD	A-B	95% CI	Mann-Witney U test
HIV/AIDS, STI's	63% 19.9	58% 20.6	5	2-8	0.00
Total Score	60% 15.8	58% 15.2	2	0-5	0.04

To test the significance of the difference between the two groups means t-test is commonly used. Mann-Witney U test, a non-paramentric test, was also used to test the difference between two groups that are based on ranked scores.

Participants from Famagusta had much less knowledge on conception compared to the participants from the other districts (Table No.7.2.3). There was also a small variation between districts on the other two subscales, HIV/AIDS, STI's and Alcohol, narcotics.

The results of an analysis of variance (ANOVA) for five scales (districts) show (as seen in table below) that the differences between districts and conception knowledge are statistically significant. F ratio shows the statistic computed in an ANOVA.

Table No.7.2.3: Conception knowledge scores, by district

Districts	n	Mean score %	SD	95% CI	F	p value
Nicosia	261	41	25.3	38-44		
Limassol	194	38	25.5	34-41		
Larnaca	120	43	26.7	38-48		
Famagusta	35	32	20.5	25-39		
Paphos	87	48	28.6	42-54		
Total	697	41	26	39-43	3.551	p<0.05

In addition, data showed that participants from urban areas seemed to be more knowledgeable than those from rural areas in two subscales, the HIV/ AIDS, STI's and the Alcohol, narcotics (Table No.7.2.4).

Table No.7.2.4: Variations in knowledge scores, by urban/rural

Groups	A. Urban % Mean score SD	B. Rural % Mean score SD	A-B	95% CI	p value
HIV/AIDS, STI's	62% 20.6	59% 20.2	3	1-7	p=0.001
Alcohol, narcotics	85% 24.4	79% 27.8	6	2-10	p<0.05
Total	61% 15.1	57% 15.9	4	2-6	p<0.05

7.3 Resources and Needs

It was found that males are more likely than females to ask their friends when they do have an inquiry/problem related to sexuality. Forty-eight percent of the males, compared to 38% of the females reported that their most frequent choice was their friends. Females were more likely than males to ask their parents when they had questions about sexuality (Table No.7.3.1 and Figure No.7.3.1). Little variance was recorded by urban/rural and districts for this. Moreover, what 'other' meant for some of the subjects, as they reported on the questionnaire, was pornographic material or books.

Table No.7.3.1: Resources for sexuality matters. Variations in gender

	A. Male %	**B. Female %**	**A-B**	**95% CI**	**p value**
When I do have an inquiry about sexuality issues, I usually ask my friends	n=161 48%	n=137 38%	10	3-17	p<0.05
When I do have an inquiry about sexuality issues, I usually ask my parents	n=84 25%	n=130 36%	11	4-17	p<0.05

Participants reported that they felt parents (50%, n=346), followed by experts (21%, n=146) were the ideal sources of sexuality information/knowledge (Table No.7.3.2 and Figure No.7.3.2). It is interesting to note that very few respondents used or perceived teachers or 'others' (including priests) as sources of information.

Table No.7.3.2: The best way of getting correct information for sexuality issues for me is from, by gender and by urban/rural location (RQ13)

		GENDER		LIVING	
	Total	**Male**	**Female**	**Urban**	**Rural**
		(a)	(b)	(c)	(d)
Base:	697	334	363	371	326
Friends	80	50	30	44	36
	11%	15%b	8%	12%	11%
95% CI	9-13	11-19	5-11	9-15	8-14
Parents	346	147	199	176	170
	50%	44	55%a	47%	52%
95%CI	46-54	39-49	50-60	42-52	47-54
Brother/ sister	19	9	10	10	9
	3%	3%	3%	3%	3%
95%CI	2-4	1-5	1-5	1-5	1-5
Teacher	27	16	11	15	12
	4%	5%	3%	4%	4%
95% CI	2-5	3-7	1-5	2-6	2-6
Doctor/ nurse	146	64	82	89	57
	21%	19%	23%	24%d	17%
95%CI	18-24	15-23	19-27	20-28	13-21
Other	79	48	31	37	42
	11%	14%	8%	10%	13%
95%CI	9-13	10-18	5-11	7-13	9-17
Total	697	334	363	371	326
	100%	100%	100%	100%	100%

Statistically Significant ($p<0.05$) – a/b, c/d
*small base

Male participants were more likely than females to report friends as the ideal source, and less likely to report parents as their ideal resource (Table No.7.3.3).

Table No.7.3.3: Ideal resources for sexuality matters. Variations in gender

	A. Male %	B. Female %	A-B	95% CI	p value
The best way of getting correct information for sexuality issues for me is from my friends	n= 50 15%	n= 30 8%	7	2-13	p<0.05
The best way of getting correct information for sexuality issues for me is from my parents	n= 147 44%	n=199 55%	10	4-19	p<0.05

In addition students from urban areas were more likely to report experts as their ideal resource of information in sexuality issues. The table below (No.7.3.4) presents this variation.

Table No.7.3.4: Ideal resources for sexuality matters. Variations in urban/rural location

	A. Urban %	B. Rural %	A-B	95% CI	p value
The best way of getting correct information for sexuality issues for me is from a doctor, nurse, specialist	n= 89 24%	n= 57 17%	7	8-19	p<0.05

Figure No.7.3.1: When I do have a question/problem related to sexuality issues I usually get information from, by gender based on all response categories
(RQ12)

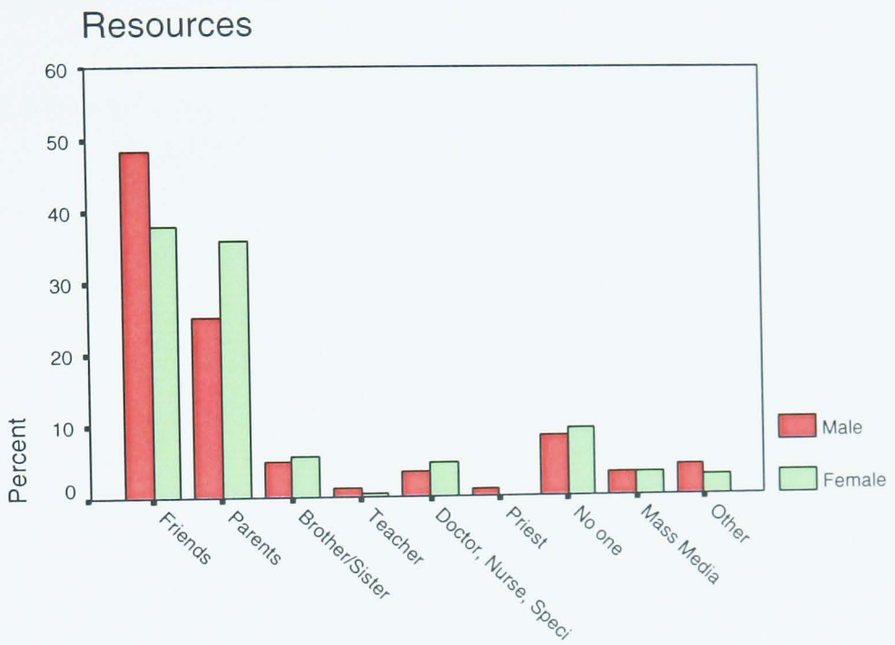
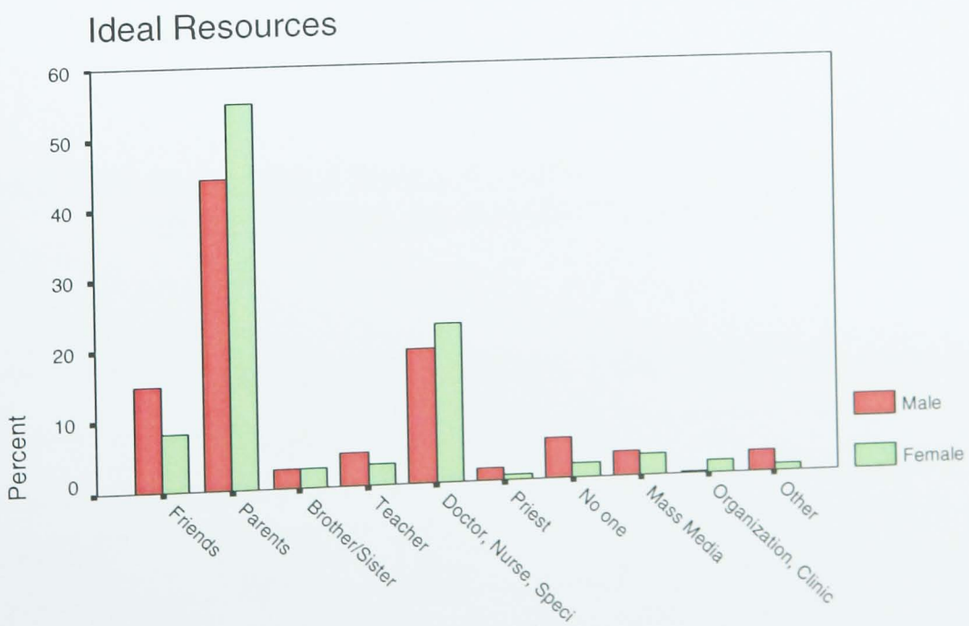


Figure No.7.3.2: The best way of getting correct information for sexuality issues for me is from, by gender, based on all response categories
(RQ13)



The majority of the subjects (55%, n=383) reported that they do not have or do not know whether there are any books related to sexuality issues in their school (Table No.7.3.5a). Females compared to males were more likely to respond positively to this question (Table No.7.3.5b).

Table No.7.3.5a: In my school there are books related to sexuality issues (e.g. conception, contraception...), by gender (RQ14)

		GENDER	
	Total	**Male**	**Female**
		(a)	(b)
Base:	697	334	363
Yes	314	137	177
	45%	41%	49%a
95% CI	41-49	36-46	44-54
No	130	84	46
	19%	25%b	12%a
95% CI	16-22	20-30	9-15
Do not know	253	113	140
	36%	34%	39%
95% CI	32-40	29-39	34-44
Total	697	334	363
	100%	100%	100%

Statistical Significant ($p<0.05$) – a/b

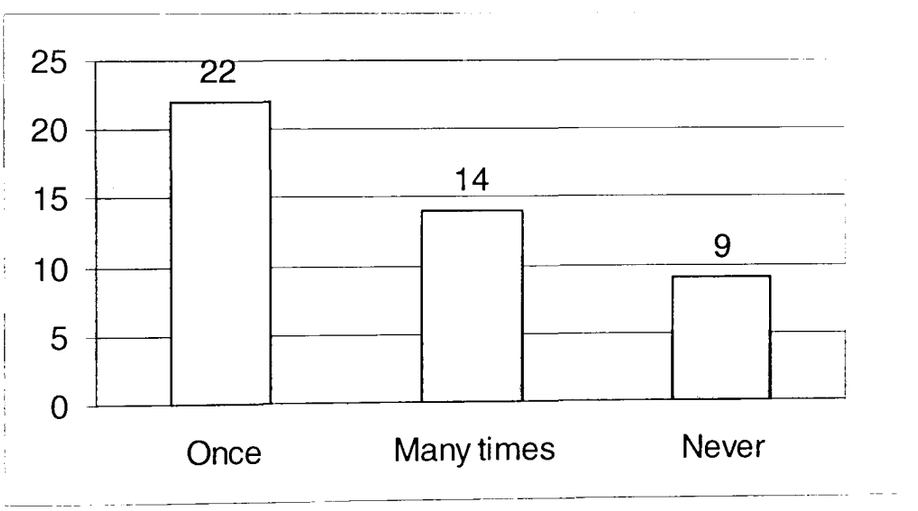
Table No.7.3.5b: In my school there are books related to sexuality issues (e.g. conception, contraception...). Variations in gender

	A. Male %	**B. Female %**	**A-B**	**95% CI**	**p value**
Yes	n=137 41%	n=177 49%	8	15-38	p<0.05
No/do not know	n=197 59%	n=186 51%	8	15-38	p<0.05

From those who did respond positively (45%, n=314; 95% CI 41%-49%), 251 (36%; 95% CI 32%-49%) students of 697 read a book at least once and 9% (n=63; 95% CI 7%-11%) they have never read such a book (Figure No.7.3.3).

Such books are available in all schools (see chapter 8). Therefore, several possibilities can be suggested: Females may visit library more often than males or be more interested in these topics or that students in general do not pay much attention to these particular books. This issue will be discussed in more detail in the following chapter.

Figure No. 7.3.3: Have you ever read any of these (sexuality) books (RQ15)



Self perceived Knowledge

Table No.7.3.6 summarizes respondents' perceptions about their own level of knowledge. For the purposes of the analysis five response categories were collapsed into two categories- very much/much and some/none. Respondents perceived themselves to have reasonable levels of knowledge about smoking (82%, n=566), alcohol and narcotics (76%, n=527). However, a large proportion of the respondents reported having little knowledge of sexual and reproductive issues. Sixty one percent (61%) of the students stated that they had some or no knowledge about conception and contraception. All these are confirmed with the findings on the objective knowledge questions (see section 7.2).

Table No.7.3.6: To what extent do you know the following subjects (summary)
(RQ16)

	TOTAL	Very much/ Much	Some/None
Base:	697	697	697
Anatomy and psychology of the reproductive system	697 100%	261 37%	436 63%
95% CI		33-40	60-67
Conception	697 100%	271 39%	426 61%
95% CI		35-43	57-65
Methods of Contraception	697 100%	274 39%	423 61%
95% CI		35-43	57-65
Sexually Transmitted Diseases (e.g. Syphilis, HIV/AIDS)	697 100%	308 44%	389 56%
95% CI		40-48	52-56
Basic principles on communication	697 100%	359 52%	338 48%
95% CI		48-56	44-52
Alcohol, narcotics	697 100%	527 76%	170 24%
95% CI		73-79	21-27
Smoking	697 100%	566 82%	131 18%
95% CI		79-85	15-21

The majority of the respondents reported that they have limited knowledge of anatomy and physiology of the male and female reproductive systems (63%, n=436). This is also confirmed with the responses on the knowledge question about fertilization (see section 7.2); eighteen percent of the respondents (18%, n= 125; 95% CI 15%-21%) answered correctly (in the fallopian tubes).

Male students were more likely to report that they had a very good or good knowledge about STI's, basic communication skills and anatomy and physiology. However, female students seemed to have less confidence of what they really know. The following tables (Table no. 7.3.7a and b) present variations in gender on self-perceived knowledge.

Table No.7.3.7a: Self-perceived knowledge on STI's. Variations in gender

	A. Male %	**B. Female %**	**A-B**	**95% CI**	**p value**
Very much/much	n=170 51%	n=135 38%	13	7-21	p<0.05
Some/none	n=164 49%	n=225 62%	13	7-21	p<0.05

Table No.7.3.7b: Self-perceived knowledge on communication. Variations in gender

	A. Male %	**B. Female %**	**A-B**	**95% CI**	**p value**
Very much/much	n=195 58%	n=164 45%	13	6-20	p<0.05
Some/none	n=139 42%	n=199 55%	13	6-20	p<0.05

Tables No.7.3.8a, b, c and d shows variation on self perceptions of knowledge of Famagusta participants compared to the participants from the other districts. Famagusta participants reported having less knowledge on anatomy and physiology, contraception and communication skills, whilst most of them reported that they have very good/ good knowledge on STI's.

Table No.7.3.8a: Self-perceived knowledge on anatomy and physiology. Famagusta compared to the other districts

	X. Famagusta %	Y. Non Famagusta %	X-Y	95% CI	p value
Very much/ much	n=8 23%	n=253 38%	15	10-30	p<0.05
Some/none	n=27 77%	n=409 62%	15	10-30	p<0.05

Table No.7.3.8b: Self-perceived knowledge on methods of contraception. Famagusta compared to the other districts

	X. Famagusta %	Y. Non Famagusta %	X-Y	95% CI	p value
Very much/ much	n=9 26%	n=265 40%	14	6-29	p<0.05
Some/none	n=26 74%	n=397 60%	14	6-29	p<0.05

Table No.7.3.8c: Self-perceived knowledge on communication. Famagusta compared to the other districts

	X. Famagusta %	Y. Non Famagusta %	X-Y	95% CI	p value
Very much/ much	n=16 45%	n=344 52%	7	11-23	p<0.05
Some/none	n=19 55%	n=318 48%	7	11-23	p<0.05

Table No.7.3.8d: Self-perceived knowledge on STI's. Famagusta compared to the other districts

	X. Famagusta %	Y. Non Famagusta %	X-Y	95% CI	p value
Very much/ much	n=18 51%	n=290 44%	7	9-25	p<0.05
Some/none	n=17 49%	n=372 56%	7	9-25	p<0.05

Respondents were also asked which issues they felt they need more information on. Table No.7.3.9 summarizes the results for each category by gender. What is striking here is the low level of perceived need of information on matters relating to sexual and reproductive health and sexuality, despite the reportedly low levels of knowledge in these areas. Table No.7.3.10 presents a comparison of objective, self-perceived and perceived need of knowledge as to view clearly these interesting findings.

Table No.7.3.9: Subject that you feel you need more information on, by gender
(KQ17)

		GENDER		
	Total	**Male**	**Female**	**95% CI difference**
		(a)	(b)	
Base:	697	334	363	
Anatomy and physiology of the reproductive system	83	41	42	
	12%	12%	12%	
95% CI	10-14	8-15	9-15	0-5
Conception	95	35	60	
	14%	10%	17%a	
95% CI	12-17	7-13	13-21	2-12
Method of Contraception	56	21	35	
	8%	6%	10%	
95% CI	6-10	4-8	7-13	0-8
Sexually Transmitted Diseases (e.g. Syphilis, HIV/AIDS)	149	77	72	
	21%	23%	20%	
95% CI	18-24	18-27	16-24	0-9
Basic principles on communication	165	73	92	
	24%	22%	25%	
95% CI	20-27	18-26	21-29	0.93
Alcohol, narcotics	47	29	18	
	7%	9%	5%	
95% CI	5-9	6-12	3-27	2-8
Smoking	22	13	9	
	3%	4%	2%	
95% CI	2-4	2-6	0-3	0-4
None	71	41	30	
	10%	12%	8%	
95% CI	8-12	8-15	5-11	0-8
Other	9	4	5	
	1%	2%	1%	
95% CI	0-2	0-3	0-2	0-3
Total	697	334	363	
	100%	100%	100%	

Statistically Significant ($p<0.05$) – a/b

Table No. 7.3.10: Comparison of objective knowledge, self-reported knowledge and perceived need

	Objective Knowledge score	Self-reported		Perceived need
		very much much	some none	
Anatomy and physiology of the reproductive system	41%	37%	63%	12%
Conception				14%
Contraception		39%	61%	
Sexually Transmitted Diseases (e.g. Syphilis, HIV/AIDS)	61%	44 %	56%	21%
Alcohol, narcotics	82%	85%	15%	7%
Basic principles on communication	-	52%	48%	24%
Smoking	-	88%	12%	3%

7.4 Attitudes and Beliefs

This section is divided into four parts in order to provide a better understanding of the findings regarding the main issues of this study: culture, gender and education for sexuality. However, it is difficult to have a distinct division of the different questions since some of them may give information for more than one concept such as gender or culture. For the purposes of the analysis five response categories were collapsed in most cases into three categories: Agree, undecided and disagree. Combining responses provides more analytical clarity to the findings of the study.

7.4.1 *Gender and Family Roles*

From data shown, males and females appear to have different views about gender, family and sexual roles. Most of the participants disagreed or reported undecided (66%, n=456) with the 'woman having the most important role in the family' (Table No.7.4.1a and Figure No.7.4.1). Table No.7.4.1b shows variations in gender of the particular statement.

Table No.7.4.1a: The most important role in the family is that of the woman, by gender
(AQ34)

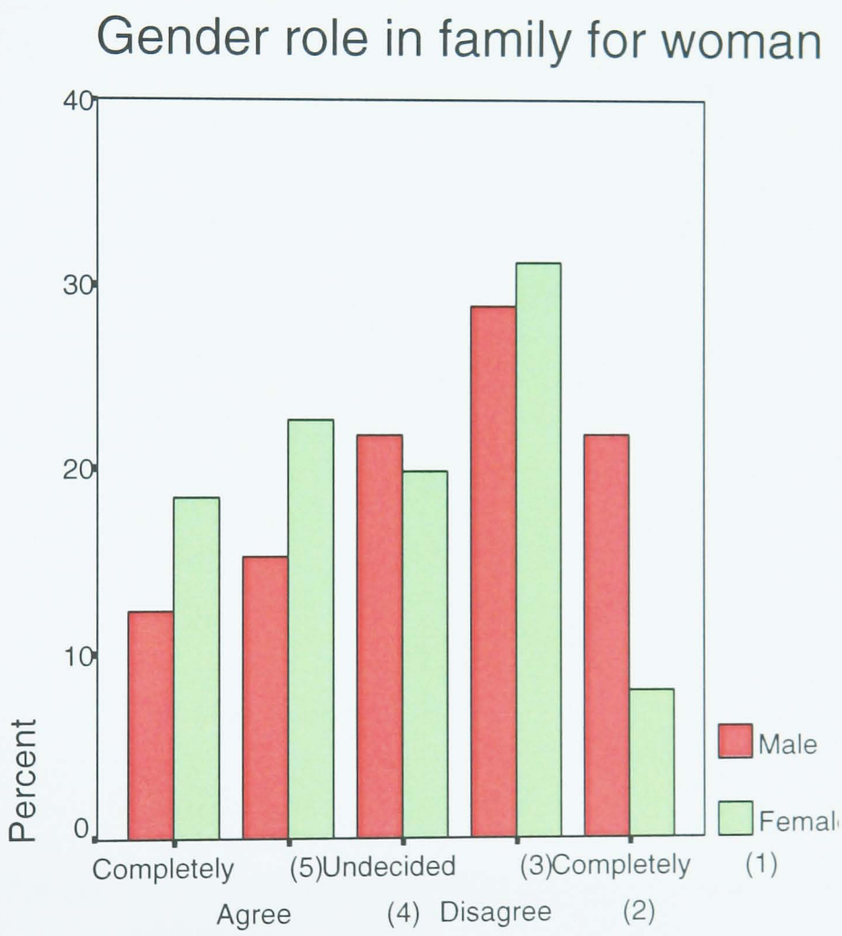
		GENDER	
	Total	**Male**	**Female**
		(a)	(b)
Base:	697	334	363
Agree	241	92	149
	34%	27%	41%a
95% CI	30-37	22-32	36-46
Undecided	145	73	72
	21%	22%	20%
95% CI	18-24	18-26	16-24
Disagree	311	169	142
	45%	51%b	39%
95% CI	41-49	46-56	34-44
Total	697	334	363
	100%	100%	100%

Statistically Significant ($p<0.05$)-- a/b

Table No.7.4.1b: The most important role in the family is that of the woman. Variations in gender

	A. Male %	**B. Female %**	**A-B**	**95% CI**	**p value**
Agree	n=92 27%	n=149 41%	14	6-20	$p<0.05$
Disagree/undecided	n=242 73%	n=214 59%	14	6-20	$p<0.05$

Figure No.7.4.1: The most important role in the family is that of the woman, by gender, based on all response categories (AQ34)



In responding to the statement that 'the most important role in the family is that of the man' 40% of the respondents agreed whilst the majority disagreed or reported as undecided (Table No.7.4.2a and Figure No.7.4.2). Table No.7.4.2b shows variations of this statement in gender.

Table No.7.4.2a: The most important role in the family is that of the man, by gender
(AQ35)

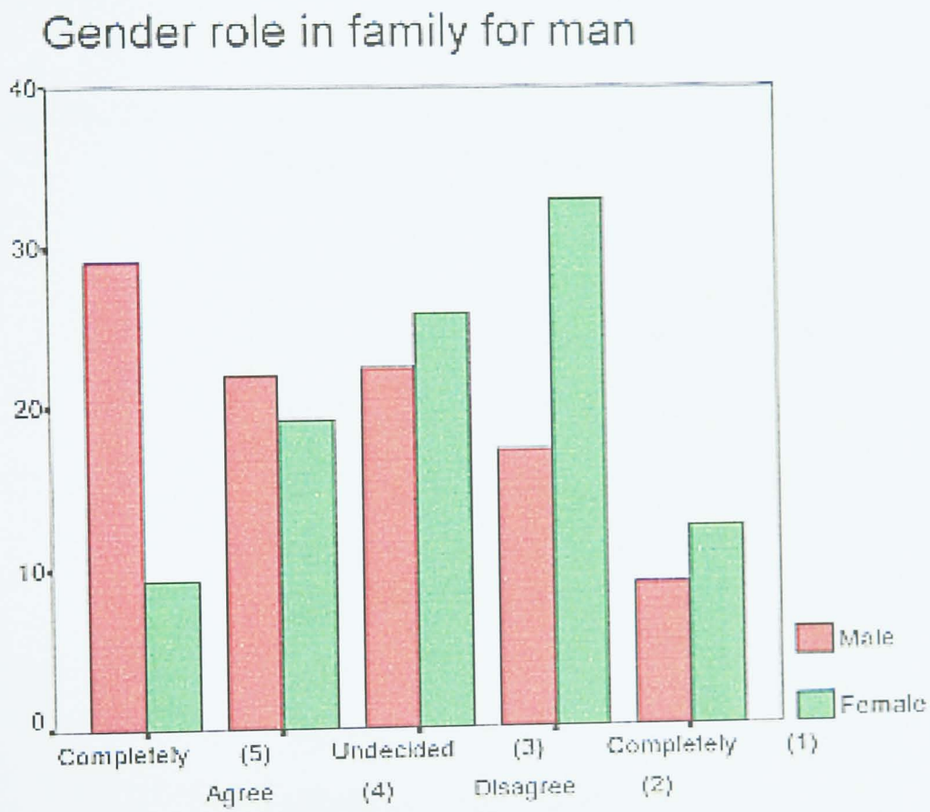
		GENDER	
	Total	**Male**	**Female**
		(a)	(b)
Base:	697	334	363
Agree	275	171	104
	40%	51%b	28%
95% CI	36-44	46-56	23-33
Undecided	169	75	94
	24%	22%	26%
95% CI	21-27	18-26	21-30
Disagree	253	88	165
	37%	27%	46%a
95% CI	33-41	22-32	41-51
Total	697	334	363
	100%	100%	100%

Statistically Significant ($p<0.05$)– a/b

Table No.7.4.2b: The most important role in the family is that of the man. Variations in gender

	A. Male %	**B. Female %**	**A-B**	**95% CI**	**p value**
Agree	n=171 51%	n=104 28%	23	15-30	p<0.05
Disagree/undecided	n=163 49%	n=259 72%	23	15-30	p<0.05

Figure No.7.4.2: The most important role in a family is that of the man, by gender, based on all response categories
(AQ35)



7.4.2 Gender and Sexual Roles

Interestingly, male participants 71% (n=237) were more likely than female respondents (55%, n=199) to report that the husband should always satisfy the sexual needs of his wife (Table No.7.4.3a and Figure No.7.4.3a). Moreover, Table No.7.4.3b shows the variations in gender. It can be said that this is an example of females being more conservative than males (see chapter 8).

Table No.7.4.3a: The husband should always satisfy the sexual needs/ desires of his wife, by gender
(AQ22)

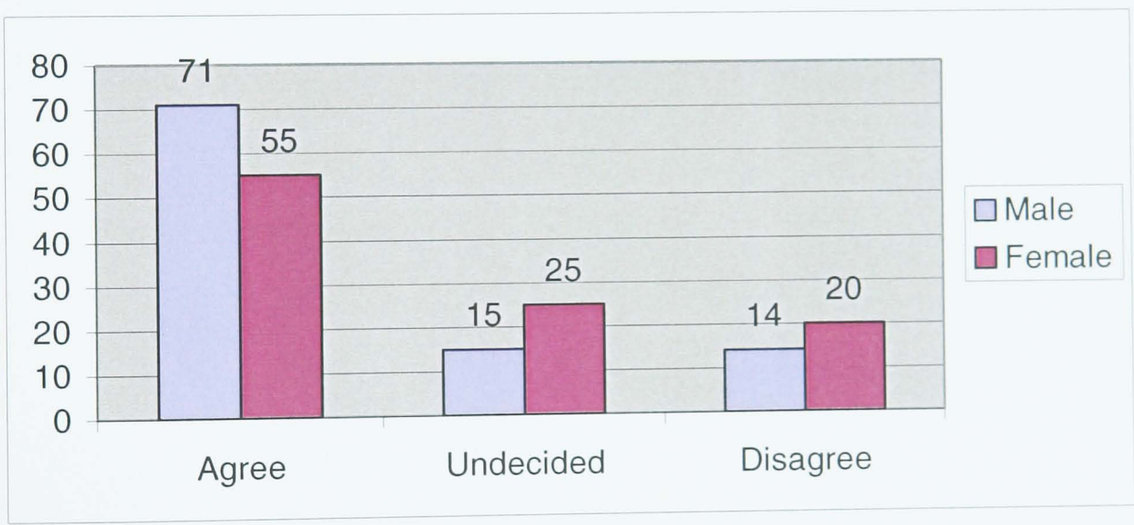
		GENDER	
	Total	**Male**	**Female**
		(a)	(b)
Base:	697	334	363
Agree	436	237	199
	63%	71%b	55%
95% CI	59-67	66-76	50-60
Undecided	142	51	91
	20%	15%	25%a
95% CI	17-23	11-19	20-29
Disagree	119	46	73
	17%	14%	20%a
95% CI	14-20	10-18	16-24
Total	697	334	363
	100%	100%	100%

Statistically Significant ($p<0.05$)– a/b

Table No.7.4.3b: The husband should always satisfy the sexual needs/ desires of his wife. Variations in gender

	A. Male %	B. Female %	A-B	95% CI	p value
Agree	n=237 71%	n=199 55%	16	9-23	p<0.05
Disagree/undecided	n=97 29%	n=164 45%	16	9-23	p<0.05

Figure No.7.4.3a: The husband should always satisfy the sexual needs/desires of his wife, by gender (AQ22)



In the statement whether a wife should always satisfy the sexual needs of her husband important differences were recorded. Male participants (72%, n=242) were more likely to agree with this statement compared to the female participants (48%,n=173) (Table No.7.4.a and Figure No.7.4.3b).

Table No.7.4.4a: The wife should always satisfy the sexual needs/desires of her husband, by gender
(AQ26)

		GENDER	
	Total	**Male**	**Female**
		(a)	(b)
Base:	697	334	363
Agree	415	242	173
	59%	72%b	48%
95% CI	55-63	67-77	43-53
Undecided	126	42	84
	18%	13%	22%a
95% CI	15-21	9-17	18-26
Disagree	156	50	105
	23%	15%	30%a
95% CI	20-26	11-19	25-35
Total	697	334	363
	100%	100%	100%

Statistically Significant (p<0.05)– a/b

The following tables (Tables No.7.4.4b and c) present the variations of this particular statement in gender and in districts, where participants from Paphos are more likely to disagree that 'the wife should always satisfy the sexual needs/desires of her husband'.

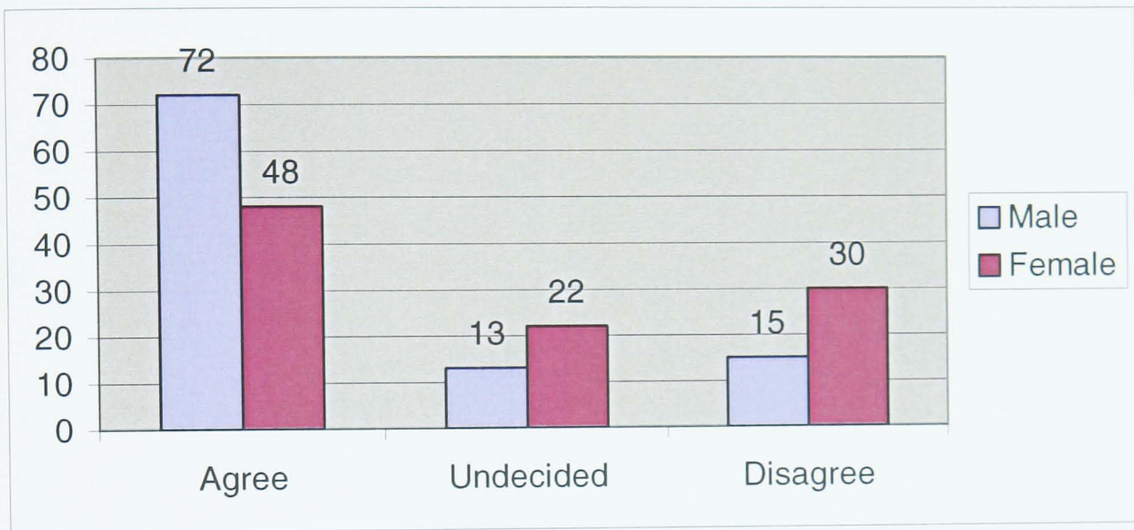
Table No.7.4.4b: The wife should always satisfy the sexual needs/desires of her husband. Variations in gender

	A. Male %	B. Female %	A-B	95% CI	p value
Agree	n=242 72%	n=173 48%	24	18-32	p<0.05
Disagree/undecided	n=92 28%	n=190 52%	24	18-32	p<0.05

Table No.7.4.4c: The wife should always satisfy the sexual needs/desires of her husband. Paphos compared with other districts

	X. Paphos %	Y. Non Paphos %	X-Y	95% CI	p value
Agree	n=40 46%	n=375 61%	15	4-26	p<0.05
Disagree/undecided	n=47 54%	n=235 39%	15	4-26	p<0.05

Figure No.7.4.3b: The wife should always satisfy the sexual needs/desires of her husband, by gender
(AQ26)



A positive relation between the above two statements was found, meaning that participants were likely to respond the same way to both questions (X^2=994.177, r=0.689, p<0.001). The correlation coefficient *r* may range from +1.00 to –1.00.

It was found that participants viewed differently premarital sexual relations for males and females. Overall, 54% (n=375) of the participants believe that is acceptable for a man to have premarital relations (Table No.7.4.5a and Figure No.7.4.4), whilst 36% (n=256) believe that is acceptable for a woman to have premarital relations (Table No.7.4.6a). In addition, data showed a positive relationship between these two variables regarding premarital relationships (X^2=649.902, r=0.560, p<0.001).

Table No.7.4.5a: It is acceptable for a man to have sexual relations before marriage
(AQ25)

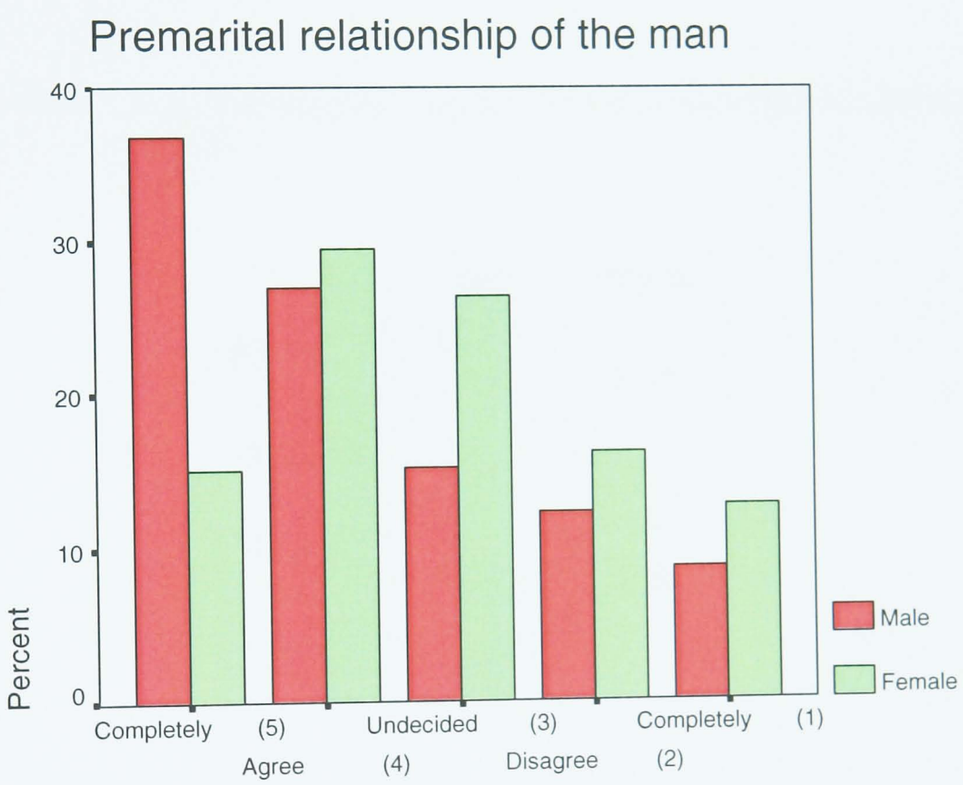
	Total	95% CI
Agree	375	
	54%	50-58
Undecided	147	
	21%	18-24
Disagree	175	
	25%	22-28
Total	697	
	100%	

Male participants (64%, n=213) were more likely to report that is acceptable for the man to have premarital sexual relationships than female participants (45%, n=162). It is also important that female respondents compared to the male respondents were more likely to report undecided (Table No.7.4.5b).

Table No.7.4.5b: It is acceptable for a man to have sexual relations before marriage. Variations in gender

	A. Male %	B. Female %	A-B	95% CI	p value
Agree	n=213 64%	n=162 45%	19	7-22	p<0.05
Undecided	n=51 15%	n=96 26%	11	5-17	p<0.05
Disagree	n=70 21%	n=105 29%	8	7-22	p<0.05

Figure No.7.4.4: It is acceptable for a man to have sexual relations before marriage, by gender, based on all response categories (AQ25)



Most of the participants reported that is not acceptable for a woman to have premarital sexual relationships (Table No.7.4.6a and Figure No.7.4.5a). Moreover, significant variations in gender and urban/rural location were recorded related to the statement that 'it is acceptable for a woman to have sexual relation before marriage' (Table No.7.4.6b and c and Figure No.7.4.5b).

Table No.7.4.6a: It is acceptable for a woman to have sexual relations before marriage
(AQ28)

	Total	**95% CI**
Agree	256	
	36%	32-40
Undecided	170	
	24%	21-27
Disagree	271	
	40%	36-44
Total	697	
	100%	

Table No.7.4.6b: It is acceptable for a woman to have sexual relations before marriage. Variations in gender

	A. Male %	**B. Female %**	**A-B**	**95% CI**	**X^2, p value**
Agree	n=143 42%	n=113 31%	11	4-19	X^2=17.741, p<0.001
Disagree/undecided	n=191 58%	n=250 69%	11	4-19	p<0.001

The table below shows that the respondents from urban areas were more likely to report, that it was acceptable for a woman to have sex before marriage than those from rural areas.

Table No.7.4.6c: It is acceptable for a woman to have sexual relations before marriage. Variations in urban/rural location

	A. Urban %	B. Rural %	A-B	95% CI	p value
Agree	n=157 42%	n=99 31%	11	5-19	p<0.05

Figure No.7.4.5a: It is acceptable for a woman to have sexual relations before marriage, by gender, based on all response categories
(AQ28)

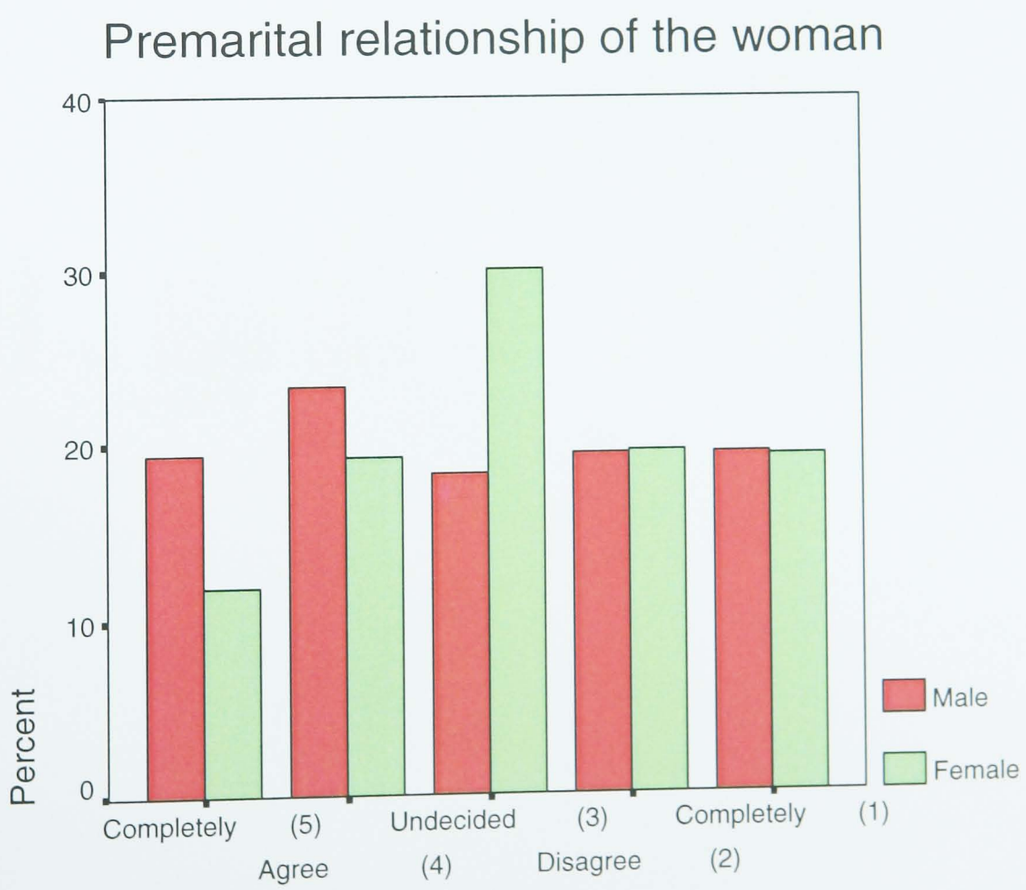
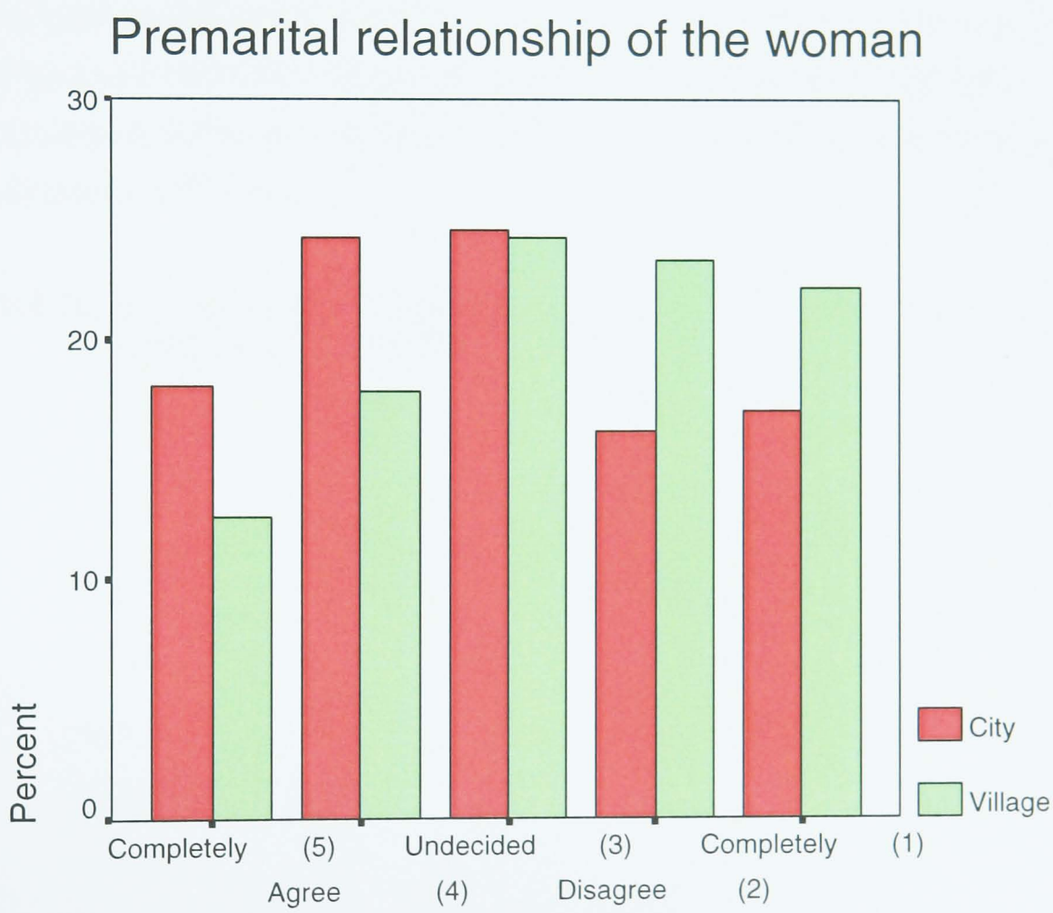


Figure No.7.4.5b: It is acceptable for a woman to have sexual relations before marriage, by urban/rural location, based on all response categories
(AQ28)



It interesting is that both genders share same attitudes and beliefs on males and females premarital relations. As tables and figures shown above an important percentage of the respondents believe that premarital sexual relationship is unacceptable for either males or females. One may argue that this is due to culturally traditional or conservative influences. This idea will be explored in chapter 8.

Most of the participants (53%, n=365) reported that their parents would not approve if the knew that they had sexual relationships (Table No.7.4.7a). The female respondents (60%, n=220) were more likely to agree, compared to the male respondents (44%, n=145).

Table No.7.4.7a: My parents would not approve if they knew I had sexual relationships, by gender
(AQ36)

		GENDER	
	Total	**Male**	**Female**
		(a)	(b)
Base:	697	334	363
Agree	365	145	220
	53%	44%	60%a
95% CI	49-57	39-49	55-65
Undecided	169	97	72
	24%	29%b	20%
95% CI	21-27	24-34	16-24
Disagree	163	92	71
	23%	27%b	20%
95% CI	20-26	22-32	16-24
Total	697	334	363
	100%	100%	100%

Statistical Significant ($p<0.05$) – a/b

Table No.7.4.7b presents variations in gender of the regarding the statement 'my parents would not approve if they knew I had sexual relationships'.

Table No.7.4.7b: My parents would not approve if they knew I had sexual relationships. Variations in gender

	A. Male %	**B. Female %**	**A-B**	**95% CI**	**X^2, p value**
Agree	n=145 44%	n=220 60%	16	10-24	X^2=24.263 p<0.001
Disagree/undecided	n=189 53%	n=143 40%	13	10-24	p<0.001

The majority of the respondents (67%, n=472) disagreed that condom use is a male matter (Table No.7.4.8a and Figure No.7.4.8). Male respondents were more likely to agree that condom is the responsibility of the man only (Table No.7.4.8b).

Table No.7.4.8a: The use of a condom is the responsibility of the man only (AQ18)

	Total	**95% CI**
Agree	162	
	24%	21-27
Undecided	63	
	9%	7-11
Disagree	472	
	67%	63-70
Total	697	
	100%	

Table No.7.4.8b: The use of a condom is the responsibility of the man only. Variations in gender
(AQ18)

	A. Male %	B. Female %	A-B	95% CI	X^2, p value
Agree	n=96 29%	n=66 18%	11	4-17	X^2=9.069 p<0.05

Figure No.7.4.6: The use of a condom is the responsibility of the man only, by gender
(AQ18)

Most of the participants (47%, n=329) disagreed that contraception is the responsibility of the woman (Table No.7.4.9a). Participants from urban areas were more likely to disagree with this and less likely to report undecided compared to the participants from rural areas (Table No.7.4.9b).

Table No.7.4.9a: Contraception, in general, is the responsibility of the woman (AQ19)

	Total	**95% CI**
Agree	208	
	30%	27-33
Undecided	160	
	23%	20-26
Disagree	329	
	47%	43-51
Total	697	
	100%	

Table No.7.4.9b: Contraception, in general, is the responsibility of the woman. Variations in urban/rural location

	A. Urban %	**B. Rural %**	**A-B**	**95% CI**	**X^2, p value**
Disagree	n=193 52%	n=136 41%	11	5-8	X^2=11.503 p<0.05

7.4.3 Sexual Relationships

Table No.7.4.10 shows that 40% (n=281) of the respondents reported that having children is the most important reason for a sexual relationship, whilst 43% (n=295) disagreed with this.

Table No.7.4.10: The most important reason for sexual relationship is to have children.
(AQ32)

	Total	95% CI
Agree	281	
	40%	36-44
Undecided	121	
	17%	14-20
Disagree	295	
	43%	39-47
Total	697	
	100%	

The vast majority of the respondents (80%, n=553) reported that 'marriage is the optimum level of male-female relationship' (Table No.7.4.11). No important differences were recorded by urban/ rural area of living, district or gender.

Table No.7.4.11: Marriage is the optimum level of male-female relationship. (AQ38)

	Total	95% CI
Agree	553	
	80%	77-83
Undecided	72	
	10%	8-12
Disagree	72	
	10%	8-12
Total	697	
	100%	

The following table shows the beliefs of respondents regarding the statement that 'contraception is a sin'. A high percentage (32%, n=226) reported as undecided.

Table No.7.4.12a: Contraception is a sin (AQ30)

	Total	95% CI
Agree	120	
	17%	14-20
Undecided	226	
	32%	28-35
Disagree	349	
	51%	47-55
Total	697	
	100%	

Famagusta participants were more likely to believe that contraception is a sin compared to the other districts (Table No.7.4.12b)

Table No.7.4.12b: Contraception is a sin. Famagusta compared to other districts

	X. Famagusta %	Y. Non Famagusta %	X-Y	95% CI	X^2, p value
Agree	n=12 35%	n=108 16%	19	20-33	X^2=18.723 p<0.05

Overall, participants who reported greater importance to religion were more likely to view contraception as a sin compared to the other participants. However, 45% (n=245) of them disagreed with the statement (Table No.7.4.12c). It can be argued that traditional religious views have some influence on young people, nevertheless they seem to be fading at least in relation to the issue of contraception.

Furthermore, it is interesting to note that students whose mothers and fathers have higher level of education reported that religion was less important in their lives (for fathers, phi= 0.235, p<0.001 ; for mothers, phi=0.183, p<0.05).

Table No.7.4.12c: Contraception is a sin, by importance of religion (AQ30ex)

	How important is religion in your life (D11)			
	Total	**Very Important**	**Somehow Important**	**Not Important**
Base:	697	533	148	16
Agree	120	107	12	1
	17%	21%	8%	6%
95% CI	14-19	17-24	4-12	0-17
Undecided	226	181	43	2
	32%	34%	29%	13%
95% CI	3-4	30-38	22-36	0-29
Disagree	351	245	93	13
	51%	45%	63%	81%
95% CI	47-54	41-49	55-71	62-100
Total	697	533	148	16
	100%	100%	100%	100%

Data suggest that participants were likely to respond the same way to the statements 'contraception is a sin' and 'the church should be involved in sexuality matters' (X^2=649.902, p<0.001).

The majority (70%, n=480) of the participants reported that a sexual relationship with a person whom they do not love is not right (Table No.7.4.13a). Female respondents were more likely to agree with this than male respondents (Table No.7.4.13b).

Table No.7.4.13a: A sexual relationship with a person whom I do not love is not right
(AQ31)

	Total	**95% CI**
Agree	480	
	70%	67-73
Undecided	59	
	8%	6-10
Disagree	158	
	22%	19-25
Total	697	
	100%	

Table No.7.4.13b: A sexual relationship with a person whom I do not love is not right. Variations in gender

	A. Male %	**B. Female %**	**A-B**	**95% CI**	**X^2, p value**
Agree	n=193 58%	n=287 79%	21	14-28	X^2=45.392 p<0.001

Furthermore, those who reported that religion is very important in their life 72% (n=380) were more likely to agree that a sexual relation with a person I do not love is not right (Table No.7.4.13c).

Table No.7.4.13c: A sexual relationship with a person whom I do not love is not right. Variations in relation to importance of religion

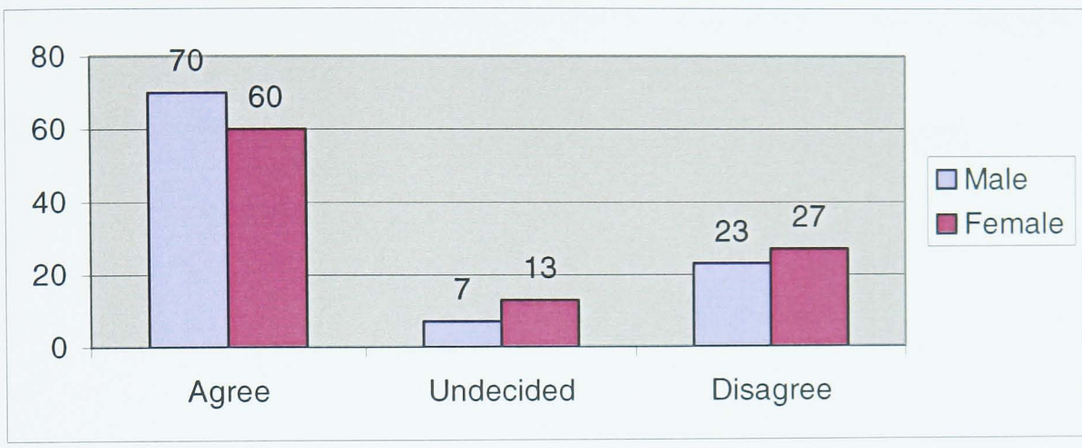
	A. Agree%	B. Other %	A-B	95% CI	p value
Very Important	n=380 72%	n=97 59%	13	4-20	p<0.05

Most of the respondents believed that a sexual relationship between two persons of the same sex is not right (Table No. 7.4.14 and Figure No.7.4.7). It can be argued that this is another issue that may be influenced by culture. This will be explored in the following chapter.

Table No.7.4.14: A sexual relationship between two persons of the same sex is not right
(AQ24)

	Total	95% CI
Agree	451	
	65%	61-68
Undecided	72	
	10%	8-12
Disagree	174	
	25%	22-28
Total	697	
	100%	

Figure No.7.4.7: A sexual relation with two persons of the same sex is not right, by gender
(AQ24)



7.4.4 Views on Education for Sexuality

The vast majority of the subjects (81%, n=570) reported that they want the school to have an active role in sexuality education (Table No.7.4.15). There was not important difference among genders, urban/rural areas or districts.

Table No.7.4.15: The school should have an active role in sexuality education
(AQ21)

	Total	**95% CI**
Agree	570	
	81%	78-84
Undecided	77	
	11%	9-13
Disagree	50	
	8%	6-10
Total	697	
	100%	

Almost all of the participants (90%, n=630) reported that they prefer sexuality education to begin in secondary school than earlier in their schooling. The majority of them seemed very cautious for education on sexuality issues to begin at earlier age and stage of schooling (Table No.7.4.16). It can be argued that this is because they do not really know what sexuality education includes or means; or they do not feel comfortable addressing such issues earlier in their school.

Table No.7.4.16: Sexuality education should begin in (AQ27)

	Pre-primary	Primary	Secondary school
Base:	697		
Agree	36	192	630
95% CI	5% 3-7	27% 24-31	90% 88-92
Undecided	51	121	27
95% CI	7% 5-9	17% 14-20	4% 2-5
Disagree	610	384	40
95% CI	88% 86-90	56% 52-60	6% 4-8
Total	697	697	697
	100%	100%	100%

Table No.7.4.17 shows participants' opinion regarding the statement that parents should teach their children about sexuality and relationships with the other gender. The majority of them (79%, n=546) agreed that. This associates with their response that parents were reported by most of them as the 'ideal' resource for these issues (as mentioned earlier in this chapter).

Table No.7.4.17: Parents should teach their children about sexuality and relationships with the other gender
(AQ33)

	Total	95% CI
Agree	546	
	79%	76-82
Undecided	86	
	12%	10-14
Disagree	65	
	9%	7-11
Total	697	
	100%	

Thirty-nine percent of the respondents (39%, n=275) did not feel that church should have any involvement with matters of sexuality education, while 29% (n=199) disagreed (Table No. 7.4.18a and Figure No.7.4.9).

Table No.7.4.18a: The church should be involved in the matters of sexuality education
(AQ20)

	Total	95% CI
Agree	199	
	29%	26-32
Undecided	223	
	32%	28-35
Disagree	275	
	39%	35-43
Total	697	
	100%	

Figure No.7.4.8: The church should be involved in the matters of sexuality education, by gender, based on all response categories (AQ20)

Respondents from Paphos were more likely to disagree with church involvement in sexuality education than the respondents from other districts (Table No.7.4.18b).

Table No.7.4.18b: The church should be involved in the matters of sexuality education. Paphos compared to the other districts

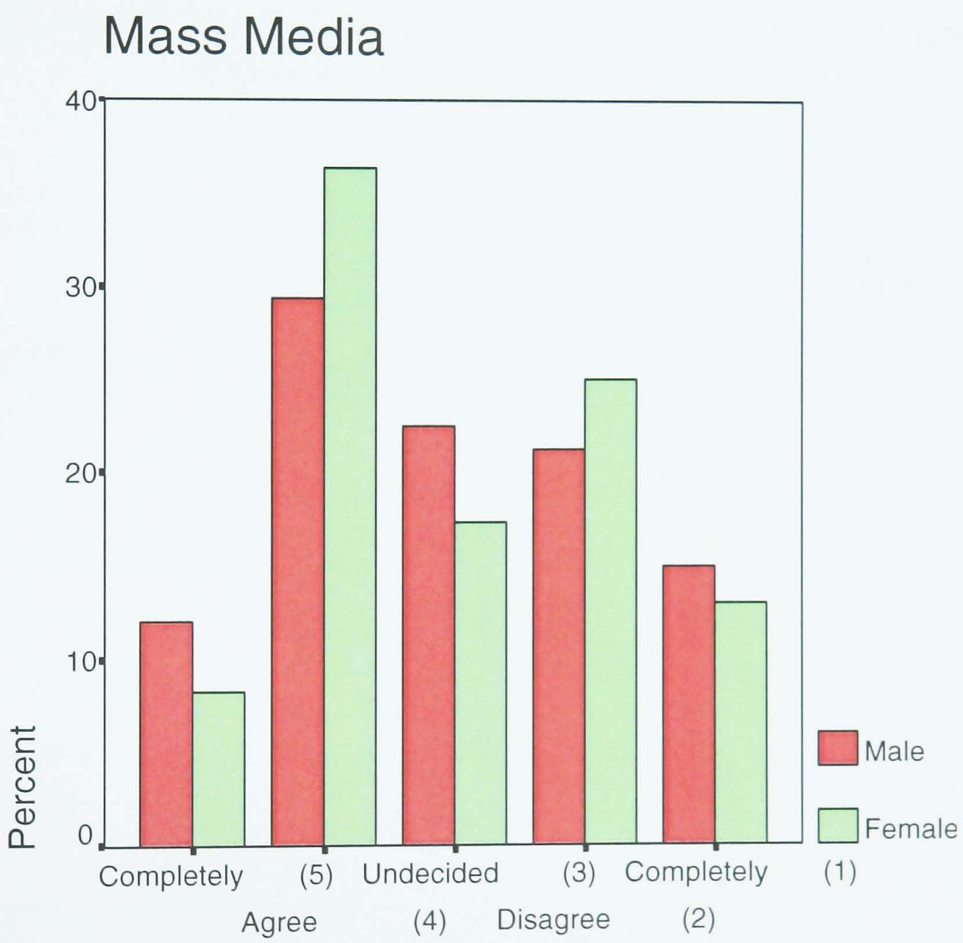
	X. Paphos %	Y. Non Paphos %	X-Y	95% CI	p value
Disagree	n=41 47%	n=234 38%	9	3-20	p<0.05

A large proportion of the participants (43%, n=300) reported that mass media (television, radio etc) do influence their beliefs and behaviour. This illustrates the important role of the media in participants' lives (Table No.7.4.19 and Figure No.7.4.6). A discussion about mass media and their impact within Greek-Cypriot society will follow in chapter 8. The proportion did not vary greatly by gender, location or degree of religiosity.

Table No.7.4.19: What I see/hear on radio, television, newspaper influences my beliefs and generally my behaviour
(AQ23)

	Total	**95% CI**
Agree	300	
	43%	39-47
Undecided	138	
	20%	17-23
Disagree	259	
	37%	33-41
Total	697	
	100%	

Figure No.7.4.9: What I see/hear on radio, television, newspaper influences my beliefs and generally my behaviour, by gender, based on all response categories
(AQ23)



Twenty-nine percent (29%, n=206) of all participants agreed that usually it is difficult to say no when someone asks something I am opposed to (Table No.7.4.20a). Meaning that they are likely to be easily influenced by someone despite their beliefs. It can be argued that this may be due to low self-esteem and/or lack of assertiveness. However, the context or issue variation may be also important.

Table No.7.4.20a: Usually it is difficult for me to say no, when someone asks me something that I am opposed to, by gender (AQ37)

		GENDER		
	Total	**Male**	**Female**	**95% CI difference**
		(a)	(b)	
Base:	697	334	363	
Agree	206	119	87	
	29%	36%b	24%	
95% CI	26-32	31-41	20-28	5-19
Undecided	105	56	49	
	15%	17%	13%	
95% CI	12-18	13-21	10-16	0-1
Disagree	386	159	227	
	56%	47%	63%a	
95% CI	52-60	42-52	58-68	9-23
Total	697	334	363	
	100%	100%	100%	

Statistical Significant ($p<0.05$) – a/b

Males were more likely to report that it is difficult for them to say no compared to females (Table No.7.4.20b). Participants with parents of higher education agreed with that statement- sixty-two percent (62%, n=58; 95% CI 58-66) with mothers with tertiary or university education; 69% (n=72; 95% CI 66-72) with fathers with tertiary or university education.

Table No.7.4.20b: Usually it is difficult for me to say no, when someone asks me something that I am opposed to. Variations in gender

	A. Male %	B. Female %	A-B	95% CI	p value
Agree	n=119 36%	n=87 24%	12	5-18	p<0.05

It is of important interest that 44% (n=308) of all respondents reported that it disturbs them to be with someone with AIDS, while 29% (n=203) disagreed (Table No.7.4.21). Despite that much education and campaigns seemed to be done for and to young people about HIV/AIDS, there is some reluctance and/or fear in accepting HIV positive individuals or people with AIDS. One may also argued, that it is somehow expected, at some degree, that the students will have fear of the unknown.

Table No.7.4.21: It disturbs me to be with someone who has AIDS (AQ29)

	Total
Agree	308
95% CI	44% 40-48
Undecided	186
95% CI	27% 23-31
Disagree	203
95% CI	29% 25-32
Total	697
	100%

7.5 Factor and Cluster Analyses

Factor and cluster analyses, as mentioned in previous chapter, are considered as exploratory data techniques. Factor analysis was used to reduce the risk of an unstable solution and for simplification. Factor analysis was used to study relations among variables and Principal Component Analysis was used for emphasis on data reduction and less on interpretation. Initially, a multiple correlation matrix of all variables was produced to ascertain whether there is some pattern of response. During the analysis of all twenty-three variables nine factors were identified, meaning that an eigenvalue for a factor was below 1. After the rotation the variance accounted for by each variable was more evenly distributed among factors. Nine components were selected and they collectively account for about 58% of the variance of the 23 variables. There was not a clear-cut since one eigenvalue was 1,013 and the next largest was below 1 (0,963). So, a solution with a different number of factors was attempted. Thus, the number of factors that decided to be extracted was specified regardless of their eigenvalues. Six components were selected and they collectively account for about 45% of the variance of the 23 variables. There was not a clear-cut since one eigenvalue was 1,180 and the next largest was 1,083 (Table No.7.5.1). So, a solution with a different number of factors was tried. Finally, four components were selected and they collectively account for about 34% of the variance of the 23 variables. There was a clear-cut since one eigenvalue was 1,480 and the next largest was 1,233. All the correlations in which *r* value was below 0.3 were not eliminated as this was not necessary to show the correlation, because it was used by default the Principal Component method. Thus, by default the correlations were analysed. Moreover, the scree plot was used to aid the decision about the number of factors (Figure No.7.5.1). Where the angle of the slope changes being an indicator of where the factors identified become less powerful.

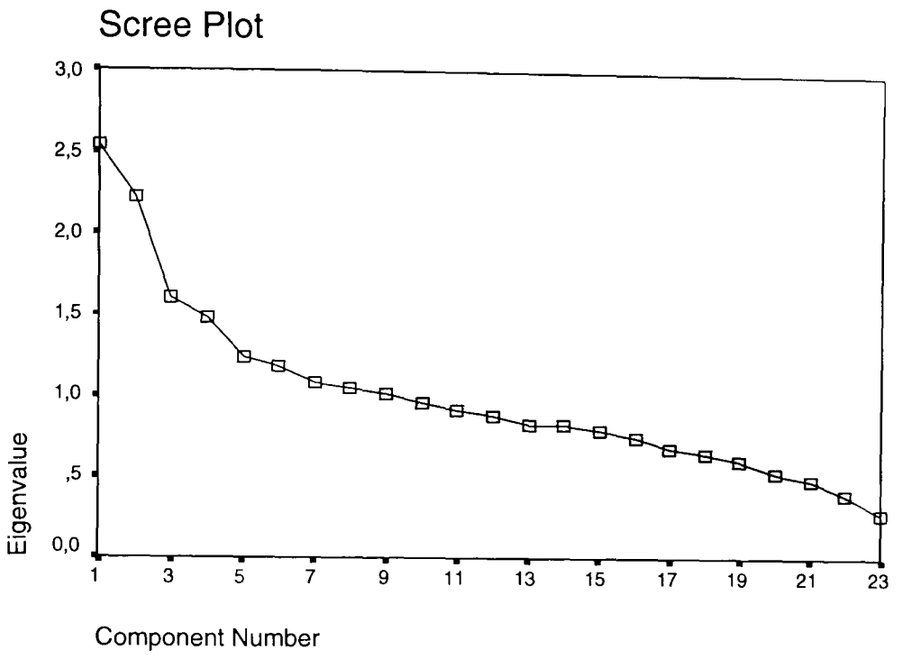
Table No.7.5.1: Principal Component Analysis

Total Variance Explained

	Initial Eigenvalues			Rotation Sums of Squared Loadings		
Component	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	**2,541**	**11,050**	**11,050**	**2,261**	**9,830**	**9,830**
2	**2,219**	**9,647**	**20,697**	**2,165**	**9,412**	**19,242**
3	**1,604**	**6,974**	**27,670**	**1,807**	**7,858**	**27,100**
4	**1,480**	**6,437**	**34,107**	**1,612**	**7,007**	**34,107**
5	1,233	5,360	39,467			
6	1,180	5,131	44,599			
7	1,083	4,708	49,307			
8	1,052	4,572	53,879			
9	1,013	4,405	58,284			
10	,963	4,185	62,469			
11	,912	3,966	66,435			
12	,885	3,848	70,283			
13	,830	3,610	73,893			
14	,822	3,576	77,469			
15	,797	3,467	80,936			
16	,755	3,284	84,220			
17	,684	2,973	87,193			
18	,656	2,851	90,044			
19	,606	2,636	92,680			
20	,529	2,299	94,979			
21	,481	2,091	97,070			
22	,396	1,721	98,792			
23	,278	1,208	100,000			

Extraction Method: Principal Component Analysis.

Figure No.7.5.1: Scree plot; component matrix 4 components extracted



Rotated factor matrix, as shown in the following table (called the Pattern Matrix for oblique rotations, Table No.7.5.2) reports the factor loadings for each variable on the components or factors after rotation. Each number represents the partial correlation between the item and the rotated factor. These correlations can help one to formulate an interpretation of the factors or components. This is done by looking for a common thread among the variables that have large loadings for a particular factor or component. Principal Component method does not require a rotation, since there is a unique solution associated with. The Varimax rotation was done to facilitate the interpretation of the components.

Table No.7.5.2: Pattern matrix for oblique rotations

	Component			
	1	2	3	4
Q.18 The use of a condom is a male matter only	,119	,416	,530	-,204
Q19.Contraception is the responsibility of the woman	,152	,381	,422	-,175
Q.20 The church should be involved in the matters of sexuality education	-5,515E-02	6,489E-02	-1,139E-02	,539
Q21. The school should have an active role in sexuality education	,155	-3,273E-02	-,130	,649
Q.22 The husband should always satisfy the sexual needs of his wife	,779	,117	-,127	,156
Q.23 What I see/hear on radio, television, newspaper influences my beliefs and generally my behaviour	4,505E-02	,166	,197	,291
Q.24 A sexual relation with two persons of the same sex is not right	-,109	,252	6,644E-03	6,033E-02
Q.25 It is acceptable for a man to have sexual relations before marriage	,531	-,333	,221	3,851E-02
Q.26 The wife should always satisfy the sexual needs of her of her husband	,823	,112	2,018E-02	8,215E-02
Q.27A Sexuality education should begin in pre-primary school	-5,002E-02	-9,674E-02	,713	,175
Q.27B Sexuality education should begin in primary school	-7,303E-02	-,171	,638	,387
Q.27C Sexuality education should begin in high school	,144	-,116	7,397E-02	,319
Q.28 It is acceptable for a woman to have sexual relation before marriage	,497	-,375	,248	5,180E-03
Q.29 It disturbs me to be with someone who has AIDS	4,635E-02	,439	5,754E-02	-1,122E-02
Q.30 Contraception is a sin	-4,987E-02	,548	6,940E-03	-1,743E-02
Q.31 A sexual relationship with a person I do not love is not right	-,309	,263	-,172	,217
Q.32 The most important reason for a sexual relationship is to have children	-,172	,597	2,846E-02	8,286E-03
Q.33 I believe that parents should teach their children about sexuality and relationships with the others	-6,663E-02	6,069E-02	8,816E-03	,597
Q.34 The most important role in a family is that of the woman	,123	,272	-9,065E-02	-1,765E-02
Q.35 The most important role in a family is that of the man	,366	,350	,284	-3,795E-02
Q.36 My parents would not approve if they know I had sexual relationships	-,136	3,770E-02	-,261	,110
Q.37 Usually it is difficult for me to say no, when someone asks me something that I am opposed to	,199	,314	,222	3,216E-02
Q.38 Marriage is the optimum level of a male-female relationship	-2,476E-02	,450	-6,887E-02	7,778E-02

As mentioned above, based on the four factors identified, four groups were formulated with the use of cluster analysis (see chapter 6). Cluster analysis suggests naturally occurring groups in data based on proximity. This was done to provide a view of the responses from a different angle: with the application of cluster analysis common responses were grouped together providing different profiles of the respondents. These profiles/characteristics enable a more comprehensive understanding of the different views of Greek-Cypriot students regarding sexuality.

Table No.7.5.3 shows the degree of success of the data's classification. Overall, 93% of original grouped cases were correctly classified.

Table No.7.5.3: Classification of data in cluster cases and its success.

Cluster Number of Cases		Predicted Group Membership				
		1	2	3	4	**Total**
Count	1	**101**	3	1	1	106
	2	7	**188**	4	7	206
	3	4	4	**206**	2	216
	4	0	5	13	**151**	169
%	1	**95,3**	2,8	0,9	0,9	100%
	2	3,4	**91,3**	1,9	3,4	100%
	3	1,9	1,9	**95,4**	0,9	100%
	4	0,0	3,0	7,7	**89,3**	100%

The four groups/clusters are descriptively given below as well as they are summarized in Tables No.7.5.4 a and b. An interpretation of these groupings will be explored in the following chapter (section 8.5). These tables illustrate for each cluster demographic characteristics, knowledge and needs of the participants and their beliefs regarding sexuality issues indicating differences among these groups. Each group should be viewed in comparison with the other three groups.

Table No.7.5.4a: Clusters 1 and 2

CLUSTER 1		CLUSTER 2
Demographics:		***Demographics:***
106 respondents		206 respondents
Males (52%)		Males (26%)
Living in rural area (60%)		Living in urban area (57%)
Have 1/more brothers/sisters (92%)		Have 1/more brothers/sisters (96%)
Mothers graduated from lyceum (22%)		Mothers graduated from lyceum (35%)
Mothers graduated from college/university (19%)		Mothers graduated from college/ university (16%)
Fathers graduated from lyceum (22%)		Fathers graduated from lyceum (26%)
Fathers graduated from college/university (16%)		Fathers graduated from college/ university (23%)
Ideal resource for sexuality issues:		***Ideal resource for sexuality issues:***
Parents (45%)		Parents (53%)
Friends (9%)		Friends (8%)
They know in a "moderate" extent:		***They know in a "moderate" extent:***
Anatomy & physiology of the reproductive system (40%)		Anatomy & physiology of the reproductive system (34%)
Conception (27%)		Conception (31%)
Sexually Transmitted Infections (28%)		Sexually Transmitted Infections (28%)
Basic principles on communication (31%)		Basic principles on communication (29%)
Want to know more about:		***Want to know more about:***
Sexually transmitted diseases (23%)		Sexually transmitted diseases (24%)
Basic principles on communication (16%)		Basic principles on communication (24%)
Conception (10%)		Conception (15%)
They consider that:		
The church should be involved in the matters of sexuality education	(96%)	(26%)
The parents should teach their children	(28%)	(3%)
The school should have an active role	(34%)	(2%)
It is acceptable for a man/woman to have sexual relations before marriage	(81%)	(97%)
The use of a condom is a male matter only	(54%)	(88%)
Contraception is the responsibility of the woman	(31%)	(67%)
Contraception is a sin	(44%)	(34%)

Table No.7.5.4b: Clusters 3 and 4

CLUSTER 3		CLUSTER 4
Demographics:		***Demographics:***
216 respondents		169 respondents
Males (61%)		Males (56%)
Living in urban area (57%)		Living in urban area (53%)
Have 1/more brothers/sisters (90%)		Have 1/more brothers/sisters (92%)
Mothers graduated from lyceum (39%)		Mothers graduated from lyceum (31%)
Mothers graduated from college/university (19%)		Mothers graduated from college/ university (16%)
Fathers graduated from lyceum (29%)		Fathers graduated from lyceum (30%)
Fathers graduated from college/university (20%)		Fathers graduated from college/ university (20%)
Ideal resource for sexuality issues:		***Ideal resource for sexuality issues:***
Parents (53%)		Parents (44%)
Friends (15%)		Friends (14%)
They know in a "moderate" extent:		***They know in a "moderate" extent:***
Anatomy & physiology of the reproductive system (30%)		Anatomy & physiology of the reproductive system (38%)
Conception (25%)		Conception (17%)
Sexually Transmitted Infections (29%)		Sexually Transmitted Infections (23%)
Basic principles on communication (23%)		Basic principles on communication (20%)
Want to know more about:		***Want to know more about:***
Sexually Transmitted Infections (17%)		Sexually Transmitted Infections (24%)
Basic principles on communication (28%)		Basic principles on communication (23%)
Conception (15%)		Conception (12%)
They consider that:		
The church should be involved in the matters of sexuality education	(41%)	(36%)
The parents should teach their children	(10%)	(4%)
The school should have an active role	(42%)	(4%)
It is acceptable for a man/woman to have sexual relations before marriage	(52%)	(27%)
The use of a condom is a male matter only	(68%)	(52%)
Contraception is the responsibility of the woman	(48%)	(33%)
Contraception is a sin	(43%)	(59%)

The following figures show the responses of each cluster on the importance of sexuality education (Figure No.7.5.1) and on the male/female premarital relations (Figure No.7.5.2). These particular statements were chosen to present here as they were considered important issues for this study and as variations in cluster can be more clearly viewed and understood compared to other statements.

Figure No.7.5.2: Importance of sexuality education, by cluster

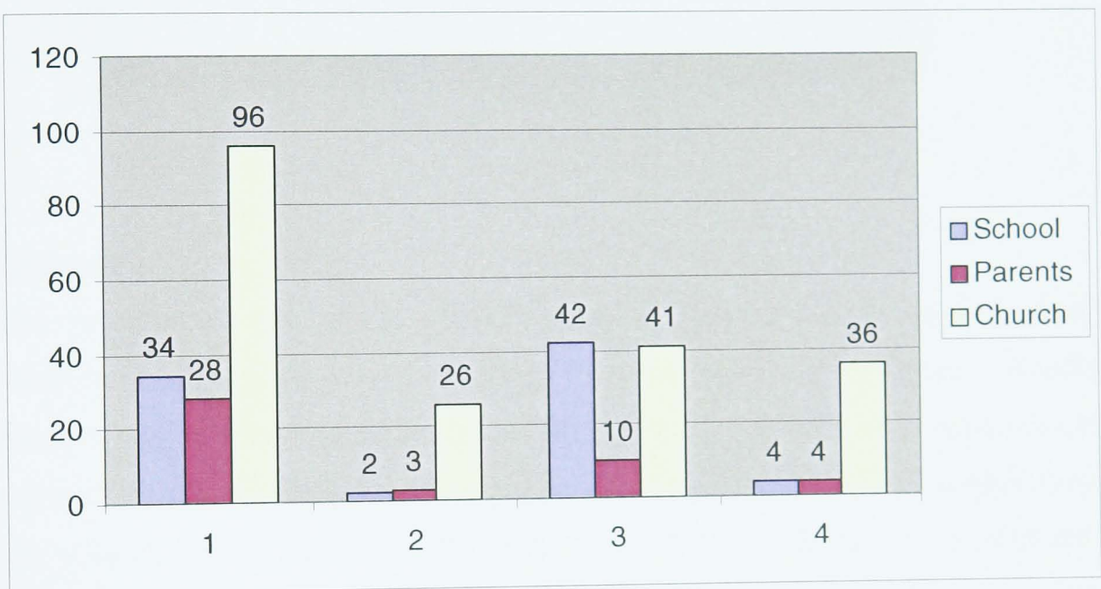
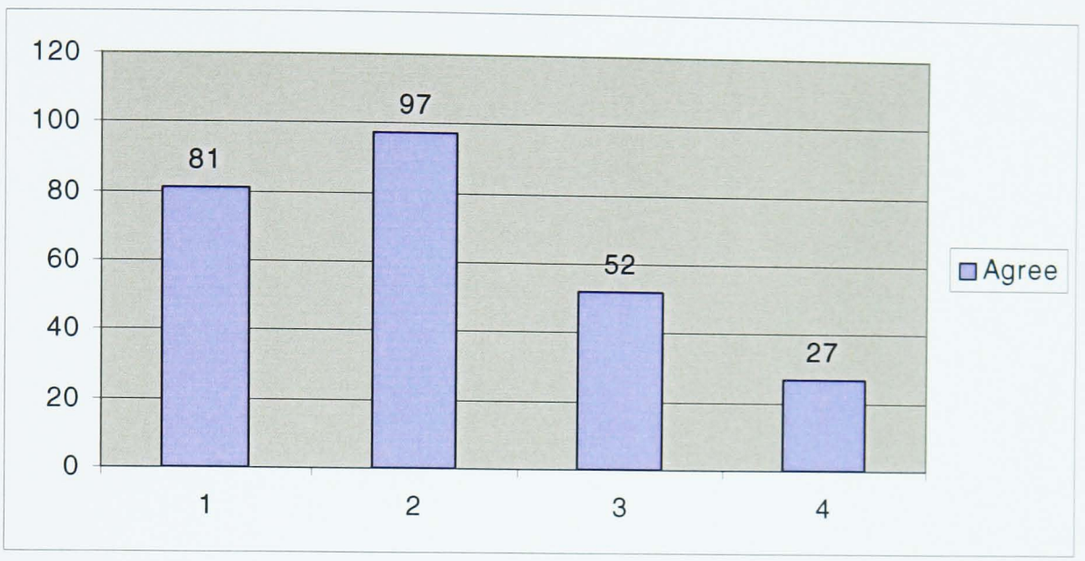


Figure No.7.5.3: It is acceptable for male/females to have premarital sexual relationships, by cluster



Summary

The findings of this study underline the impact of culture and gender in relation to sexuality issues among Greek-Cypriot adolescents. However, these findings which describe the situation in Cyprus may also apply to other cultural groups. Cultural issues such as dropi and shame (see chapter 5) exist not only in Cyprus but in most collectivist cultures. Moreover, in this study religious issues and the role of the church were found to be a strong influencing factor in forming adolescents' attitudes and beliefs regarding sexuality. Nevertheless, these results may be applicable to societies or cultures with characteristics similar to the Cypriot culture.

For the presentation of the results, the division of participants' responses in different sections was felt to be important for better and clearer understanding of the data and for easier interpretation of the findings. However, there is no distinct line in presenting the data, especially in section four, since all concepts/areas are interrelated and data can provide important and useful information in one or more of these concepts.

The following chapter will present an interpretation and discussion of these results.

CHAPTER 8

DISCUSSION

Introduction

In this chapter the research findings are discussed and evaluated with reference to studies and theories previously presented in this study (chapters 2-5). A theoretical explanatory framework aiming at understanding sexuality of Greek-Cypriot adolescents is developed, presented and discussed.

8.1 Limitations of the Study

According to Polit and Hungler (1991:22) "...perfectly designed and executed studies are unattainable". Each research study though adds to a body of accumulated knowledge. No single study can give a definite answer to a given question. Thus, the researcher many times makes decisions on how to proceed having in mind the limitations of his/her study.

In this study, even though the questionnaire was based on other questionnaires and many questions were combined from those; new questions were also formulated creating a new questionnaire. Thus, generalizations should be treated with caution. Furthermore, the findings for Famagusta and Paphos districts should also viewed carefully because of the their small sample.

Cluster sampling, as previously mentioned, increases the homogeneity of the group, however this was counteracted with the use of Collin's calculation taking this parameter into consideration (see chapter 6). Therefore, these limitations are important in order to interpret, discuss and understand the findings of this study.

8.2 The Profile of the Respondents

The respondents were third grade students in secondary school in general public education in both urban and rural areas of Cyprus. Their average age was 14 years and their gender representation that was almost equal (48% males and 52% females) follows the overall gender census of student population in Cyprus, slightly more girls than boys.

Almost all of them (90%) were from a small nuclear family, meaning that they were living with both parents, having none-two siblings (79%), something that is also a characteristic of contemporary Cypriot family. It was found though that most of the participants from Nicosia, Limassol and Paphos have one sibling, whereas most participants from Larnaca and Famagusta have three or more siblings. In this study Famagusta participants reported some variation from the other districts as presented in section 8.2.1. In a recent study in Cyprus a strong association was found among the educational level of the individuals and the number of children they have or planning to have; highly educated persons were more likely to have or want to have fewer children (Lambraki, 2003).

It is significant that students from urban areas have more educated parents than students from rural areas. This is interesting since students from urban areas seemed to be more knowledgeable in sexuality issues than those from rural areas (see section 8.3). One may argue, that people from urban areas had and still probably have more economic comfort and/or are more open-minded. Economic comfort provides a fruitful space for education and open-mindness eases the understanding of controversial and sensitive issues such as sexuality. Thus, people from urban areas could comprehend and accept more easily sexuality issues rather than people from rural areas. Furthermore, it can be said, that there is a difference in studying between an urban and rural school: Educational stimuli may be different such as having fewer or smaller libraries in rural areas; also, some rural students have less time for

study as due to their economic circumstances some of them have to work in their parents' agricultural farms after school.

The vast majority (98%) of the respondents were Greek-Orthodox. Whilst a large percentage stated that religion was very important in their lives and their families, 40% of them did not regularly or never attend church services. A recent study of Cypriot young people, found that 50% of the respondents attend church on important occasions such as Easter and Christmas (Cyprus Youth Organization, 2002). Even though church has a dynamic presence within the Greek-Cypriot society, Christian orthodoxy occasionally conflicts with the Greek culture and the contemporary way of life and thus, some people do not adhere strictly to Christian principles (Papadopoulos, 2002). There might also be the belief that presence in the church does not necessarily make one more religious than the one who does not attend but deeply believes in Christianity. On the other hand, a deeply religious person that feels close to God, probably feels the need to participate in Church sacraments every week or even more often. These can be some factors that influence church attendance.

8.2.1 Famagusta Respondents' Profile

In this study it was found that Famagusta participants had interesting differences compared to the participants from other districts. Although they were the smallest group the researcher decided to refer to it as some of these findings are considered as indicative of Famagusta's young people attitudes and beliefs related to sexuality and important to the Cypriot society:

- They come from larger families, having three and more siblings.
- Twenty percent (20%) of them live with their mothers only or someone else apart from their parents such as stepfather, stepmother, grandparents and foster families; and this was found to be statistically

significant compared to the students from other districts (see section 7.1).

- They have less educated parents: Most of their mothers (66%) and fathers (69%) had graduated from elementary school and/or gymnasium (junior high school) only.
- Although the majority of the Famagusta respondents are Christian Orthodox, other religions exist within the Famagusta community, in a higher percentage than within other communities/districts (3% Maronites, 3% Jehovah's Witness).
- They reported to attend church much more often than participants from other districts.
- They were more likely to agree that contraception is a sin compared to the other districts and this was found to be statistically significant.
- Regarding their knowledge on sexuality issues, overall they seemed to be less knowledgeable than the rest of the participants (see chapter 7). It was found that participants from Famagusta had the least knowledge on conception.
- Participants from Famagusta were more likely to perceive themselves having less knowledge on anatomy and physiology of the reproductive systems, contraception and communication than the other districts. However, on self-perceived knowledge they were more likely to report having more knowledge on STI's compared to the other districts.

8.3 Knowledge related to Sexual and Reproductive Health

One of the aims of the study was to describe the knowledge of young students related to sexual and reproductive health, including factors which may influence sexual behaviour such as drugs and alcohol. Alcohol and narcotics are related with sexuality because use and misuse of either of them may directly influence one's ability to make clear decisions and choices. The findings indicate that participants have a good knowledge about narcotics and alcohol. This is probably due to the fact that considerable emphasis was given to these two areas by the Ministry of Health, Ministry of Education and Culture, school, mass media and the police during the past several years. This confirms the findings of Veresies and Pavlakis (1994) who found that students had some knowledge about alcohol and several narcotic drugs. In their study, more than half of the young people involved (64.5%) knew that alcohol influences one's health such as, inducing physical and psychological dependency. Since the publication of their study, much work has been done in Cyprus on these issues, such as training the teachers/educators, informing the students and forming health promotion teams for narcotics within the schools. In addition, these issues appear to be easier to discuss openly, thus educators feel relatively comfortable in teaching these particularly as the benefits of having such discussions seems more obvious to all (educators, students, parents, educational authorities, church, politicians). It is interesting to note that the inclusion of drug awareness in the schools was accepted without questioning or disagreement. Even the Church of Cyprus fully supported this and some church representatives are actively involved by being members of relevant boards or offering financial and personal help to those affected by drug misuse. The Media also reinforces the whole approach of drug awareness through current affairs programmes and advertisements. There is a continuous promotion by mass media of drugs prevention information; telephone helplines that offer information about drugs and

support to those affected by drug misuse, are regularly featured. Stories regarding drug users have been covered on several occasions.

In contrast to the positive and dynamic way that drug abuse and drug education is being addressed in Cyprus, sexuality remains a controversial matter. Whilst sexuality education is viewed with skepticism and criticism and despite the fact that since 1992 'Sexuality and Family Education' programme (as it was called) formed part of the health education curriculum, the knowledge findings of this study reveal that this has only partially succeed, either because certain parts of the programme were not adequately covered or because those who delivered it did not effectively do so. For example, students seemed to have some knowledge on HIV/AIDS, STI's and limited knowledge on matters related to conception. In addition, students reported their need in psychosocial aspects of sexuality such as communication among genders. Both genders reported having limited knowledge on sexuality matters. Interestingly, male students were found to have significantly higher level of knowledge regarding HIV/AIDS and STI's. One may argue, that this may be due to the fear of infection since they considered themselves more sexually active, and thus they may often get additional information from friends and magazines.

Despite that an important percentage (61%) answered correctly on HIV/AIDS, STI's related questions a large percentage (41%) answered incorrectly. It is of special interest that the majority of the respondents (69%) were unsure if HIV/AIDS can be transmitted by mosquitoes. This is a common myth in Cyprus which reflects the people's fear of the disease and which continues to worry them even though there are no reported cases infected by a mosquito. However, the identified gap of knowledge regarding sexuality issues is of concern and indicates that the methods used to promote it are either ineffective or inadequate. The Cypriot conservativeness or the feeling that this kind of problems are more 'foreign' than local are two reasons that reduce the efforts that need to be made in order to treat the issue with the seriousness it

requires. Another reason could be the fear of revealing 'unacceptable' behaviour such as homosexuality, premarital or extramarital relationships within Greek-Cypriot society. As discussed in chapter 5, for the Cypriot society issues related to sexuality are highly moral and any deviation from what is accepted as the norm, is highly offensive to one's family. Society, through the preaching of the church, promotes family values and the purity of women, whilst it continues to castigate individuals who challenge the norm. Such strong moral codes discourage open discussion on sexuality issues as this may be viewed as a challenge to them. Initiating moral discussions requires leadership, commitment, sensitivity and a clear vision regarding the consequences. Thus it may be easier to go along with the 'status quo' or to try and deal with contentious issues using less overt tactics. This may explain the reported need for more knowledge about issues that may be seen as morally laden such as conception and the psychosocial aspects of sexuality such as communication among genders, in contrast with the reported good levels of knowledge on issues that are perceived as less morally bound -although risk associated-, such as HIV/AIDS, drugs and alcohol. It may also explain why participants from rural areas were found to be less knowledgeable than those from urban areas. Even though the distance between urban and rural areas in Cyprus is minimal, and young people from rural areas can interact with young people from urban areas, it appears that the emphasis on family honour, the effect of gossip, have a bigger impact on those young people who live in smaller communities.

Further, it is worth noting that Cyprus health care system is very medically and disease oriented which means that psycho-social and cultural determinants of health are undermined. Therefore, the sensitivity of a morally perceived complex subject, and the readiness of a teacher/educator to teach it are some of the obstacles in delivering knowledge for sexuality.

In this study, the subject which respondents reported to have least knowledge of was that of conception/contraception. Respondents from Famagusta, that

is mainly rural area, reported much less knowledge on this compared to the rest of the districts.

Contraception is included in the Anthropology book of the second grade. Nevertheless, most of the respondents have minimal or no knowledge regarding the contraceptive pill. An important percentage difference was recorded between urban (38%) and rural (25%) areas about the statement that 'contraceptive pill does not protect you from any STI'. This adds to the earlier discussion that rural students have less knowledge on sexuality issues than urban students.

As discussed in chapters four and five the teacher's background, knowledge, personality and idiosyncrasy can have a positive or negative impact on the whole programme. Interestingly, in the question about the condom and its safety regarding STI's, female participants reported an important lack of knowledge, although they believe that they have also responsibility to know about condoms. A statistical significance was reported between genders on this (males=29% Vs females=18%, $p<0.05$, see chapter 7). Furthermore, it cannot be ignored that the vast majority of the students (85%) have no idea where fertilization takes place. This question was considered to be basic knowledge of anatomy and physiology. This subject is taught at the end of the second grade. The specific section is included in the Anthropology book of the second grade under the chapter of male and female reproductive systems. One may argued, that leaving it as the last chapter it may not be given adequate time for students to understand, discuss and comprehend thus creating more difficulty to recall knowledge.

Issues like contraception must be viewed within a socio-cultural and psychological context and less within a medical context. For example, issues and/or concepts such as gender, religion, values and family environment are better to be taken in consideration when discussing contraception. The criterion for one to choose a contraceptive method is not primarily whether it suits one's biological system, but rather than to have a harmony with one's

ecological system, meaning that one should be viewed holistically, including his/her beliefs, religion and culture (Kotchick at al., 2001).

Some argue that, medicalization may move individual's control over life (Hillier in Scambler, 1991). The medicalization thesis argues that there is a tendency for medicine to expand its claims and critics suggest that social problems are redefined as medical ones (Hillier in Scambler, 1991). As will be discussed later in this chapter, the current and proposed sexuality education programmes have and will mainly have a medical orientation. Sexuality must be viewed outside medicine, but within culture mainly. This idea of medicalization does not depict the main concepts of health promotion. As mentioned above, a person should be viewed as a bio-psycho-social entity, as a whole. "The concept of health encapsulated a recent development to treat health related aspects of sexual behaviour holistically" (Wellings and Cleveland, 2001:238). Health promotion provides the knowledge and skills as to empower the individual to have choices and control over his/her health.

There is evidence from some randomized trials that sexuality education may increase knowledge but does not reduce sexual risk taking in young people, while several quasi-experimental studies concluded that it is effective (Wight et al., 2002). Thus, education for sexuality is more complicated than delivering just plain knowledge and information. In the Netherlands and France live birth rates among the ages 15-19 have been reduced (Kiddy, 2002). One of the reasons of this success could be a well-structured programme based on skills development and cultural needs. While the content of such programmes is important, the teaching methodology that is applied as well as the personal and professional preparation of the educator is crucial (see section 8.4). In sexual health interventions that have been designed by adolescents, they suggested that sexuality education should have less focused on anatomy and scare tactics (Appendix No.10). It should be more positive focusing on negotiation skills and communication (DiCenso et al., 2002). Thus, it can be said that as the sexuality programme that the

Ministry of Education and Culture seems that is going to adopt is a medically-oriented one, its success is doubtful. Even if students increase their level of knowledge, their negotiation and communication skills and their understandings about themselves will probably not be developed or explored much.

According to Wight et al. study (2002), improvements in teachers' related skills have some beneficial effect on the quality of young people's sexual relationships but do not influence sexual behaviour. Based on this finding a critical analogism can be made: when the quality of a sexual relationship changes it is expected that there will be some degree of change in sexual behaviour. Since sexual behaviour is part of a sexual relationship, it is expected that some alteration in behaviour will occur.

In DiCenso et al. study (2002), 26 studies that evaluated strategies aiming to prevent unplanned pregnancies in adolescents were reviewed. According to their study, primary prevention strategies do not delay the initiation of sexual intercourse or improve birth control among young men and women. However, most of the participants in all these studies were African-American or Hispanic therefore, findings may differ in other populations. Those studies were aiming to prevent unwanted pregnancies and the result is unknown if the focus was to understand one's own sexuality researching the impact of socio-cultural determinants in adolescents' sexuality. This is important as to emphasize that any programme no matter how successful may be in one country or population, does not guarantee its success in another. The uniqueness and diversity of each group, country and /or society should not be ignored.

Since no evaluation has been reported for the existing Sexuality and Family Education programme in Cyprus, it will be too risky to begin a new one, even if it is considered to be a better one. An evaluation will identify weaknesses and/or strengths of the existing programme. Therefore, reforming, changing and/or adding to it will improve the programme in its whole. The present programme does not emphasize any socio-cultural factor that may influence

adolescent sexuality. Additionally, one of the newly proposed programme, the multi-thematic one (as it is currently called) discusses significant concepts of sexuality, but still the role of socio-cultural determinants is undermined. The alternative proposed programme, which is medically-oriented, will offer even less opportunities for discussion of such concepts.

8.4 Resources and Needs

Although most of the participants reported that their ideal resource when they have an inquiry/problem related to sexuality is their parents, they also reported that they usually seek help from friends. These findings are compatible with the findings of Ketting et al. study (2001). It was also found in this study that more adolescent girls ask their parents for information than adolescent boys and this was found to be statistically significant. It is more likely that adolescents, when they do ask their parents about sexuality issues, they usually prefer to ask their mothers than their fathers (Santrock, 1989). In Ketting et al. study (2001) almost half of the adolescents (41%) reported to prefer getting information from their mother. Arguably, communication of such issues may be seen by many people as being part of the 'female' or 'mother' role within the family. According to the Research and Development department of Intercollege (2000) in their study about Greek-Cypriot women, the vast majority (96%) of the participants reported that women's primary role is mothering and nurturing of children. It is obvious that Cypriot society is mainly traditional. Therefore, mothers are more likely to communicate more with adolescents compared to their fathers. Despite this, many adolescents in this study chose not to discuss sexuality issues with their parents. This may be due to several reasons such as conservativeness, taboos, lack of knowledge, fear of the challenge or rejection by the parents. It also depends on the relationships and communication within the family. In cluster analysis it was found that overall all groups had limited communication with their parents

(see section 8.6). Moreover, it can be according to one's own self-identity and self-confidence or due to parents' lack of knowledge. Peer pressure is another important dynamic in sexual attitudes and behaviour; and often adolescents are guided by other adolescents to use the resources they use because is easier and generally accepted. In a study done by the Cyprus Youth Organization (1997), young participants reported that they prefer to discuss personal relationship matters with their friends. Friends and or groups/parties -'parea'- are important part of Greek life. These groups can be of the same or opposite gender. Males often gather in a coffee shop or kafeteria to talk and do metaphorical kamaki (spearfishing), which suggests sexual 'hunting of women'. These actions represent a personal ethos, a worldview for men and a description of their masculinity (Loizos and Papataxiarchis, 1991). Thus, it is easier for adolescents to discuss sexuality issues with friends rather than their parents. In addition, many times -this is more common for males- in order to belong to the group they have to describe, talk or boast about their sexual prowess with the group. Females' discussions on sexual issues are more limited and this may be due to the cultural expectation of preserving their 'honor' and avoid gossip.

In this study, less than one third of the respondents reported as the ideal resource a nurse, doctor or a specialist. More adolescents could use the expertise of people or organizations if they were accessible and known to them. In addition to this, participants from urban areas were more likely to seek professional help compared to those from rural areas. In Cyprus, as mentioned in the literature review, there are limited resources for adolescents' health, especially in sexual health which are almost non-existent in rural areas (see chapter 5).

More than half of the respondents (55%) reported that they do not have or do not know having any books related to sexuality issues in their school.

Actually, there are several books that include sexual and/or reproductive issues such as:

- Anthropology (2nd grade secondary school). Includes the male and female reproductive systems, conception, pregnancy, puberty, contraception and STI's.
- Home Economics (3rd grade secondary school). It includes the subject of adolescence.
- Family Education-Infancy/child development care (5th grade secondary school). It includes marriage, family, conception, pregnancy, STI's, contraception and family planning. This is an optional class.

Therefore, either students do not read or pay attention to the books and/or to their teachers or limited connection has been made between these topics and sexual health. The availability by school libraries, of books, videos or computer programmes on sexuality issues, is limited. However, some schools do have a good cooperation with the Cyprus Family Planning Association (CFPA) and often the staff and experts from the organization are invited to schools as to talk about different sexuality matters. This collaboration depends entirely on the teacher and/or head teacher of each school. The CFPA is a valuable resource in Cyprus not only for students, but for teachers and parents too. Another argument could be that gender is a factor, since females reported knowing more about the existence of sexuality books. Several reasons can be thought about this such as: Adolescent girls want to know more or acknowledge their ignorance and thus want to learn or visit the library more often or that adolescent boys have other interests than studying such issues or even that they may fear to admit their ignorance on this particular matter. A cultural explanation regarding gender may be also given-males are supposed to know more, be more sexually active and guide females thus they acquire this role without necessarily having the knowledge or interest to know.

The urge to prove their masculinity as well as being a 'macho man' are valued in the Greek-Cypriot culture. Even if one does not know about sexual issues he will probably not dare to admit it to his male peers from the fear of rejection from the 'macho group'.

Although textbooks can be considered as an acceptable resource for certain sexual and/or reproductive issues, the quality and quantity of the education given depends on the teacher. To be a Biologist or Home Economist does not make someone necessarily an expert to teach sexuality education, however this is not unrealistic. Teachers/educators do have paedagogical skills and this is an asset compared to other professionals such as doctors and nurses who are also involved in sexuality education in Cypriot schools. The educator whoever they might be, apart from knowledge on sexuality issues he/she needs to feel comfortable to explore such sensitive topics as well as to be able to apply a variety of experiential learning methodologies aiming to promote adolescents' sexual health and their understanding of sexuality. Thus, training of educators/teachers is a priority as to reinforce their personal and professional development related to sexuality issues and consequently be able to teach such issues. In the Cyprus Youth organization (1997) study more than half of the participants reported having some trust on their schoolteachers, while less than one third reported that they trust them much or very much. This is encouraging. However, educators/teachers should not be complacent but continue to work towards developing trusting relationships with their students as to successfully deliver sexuality education, aiming in forming or reforming attitudes and beliefs.

According to Kiddy (2002), education for sexuality matters comes too late for many adolescents. In Cyprus, the pilot studies for sexuality education were applied in third grade (13-14 years old) secondary school students. This is the age that sexuality education programme is planned to be applied. At the ages of 13-15 some people might have already started sexual relationships (Kiddy,

2002). Although this does not apply in general to Greek-Cypriot adolescents, in recent years several cases have been reported through the mass media or informally from educators or gynaecologists of pregnancies and abortions at this age. However, there is no scientific evidence to support this for Cyprus. Even though the topic of adolescence is also taught in Cyprus during secondary school first grade (age12), it seems that there is a need for more detail information, appropriate to the age that may be as early as that grade. It may be argued that, some themes such as conception, 'where babies come from', should be taught also in elementary school and repeated and explored in more depth in secondary school. Nevertheless, conception related matters were the weakest knowledge area of the participants.

8.5 Attitudes and Beliefs

Cypriot adolescents are influenced by their immediate environment and generally Greek culture. The findings revealed that Cypriot adolescents hold a range of attitudes from the more liberal ones to the more traditional ones. The findings also indicate that there are several gender differences in attitudes and beliefs related to sexuality matters.

Gender and Family Roles

Family is very much valued in the Greek-Cypriot society. Traditionally the man is the head of the family and many young people support this idea. Fifty-one percent of the male participants and less than a third (28%) of the female participants believe that 'the most important role in the family is that of a man'. Males seemed to be constant with their beliefs regarding gender roles. Most of them want themselves to be the leader of the house, as this has been cultivated throughout the years. Males also seem to have less confidence to

the females' abilities as leaders. Females themselves, although many of them want to have an important role within family, and to introduce a more equal and liberal way of life, they are not so convincing. On one hand they want initiatives and have the most important role in the family (41%), whilst on the other hand somehow they want the male as the leader of the family (28%). They want to be liberal, however traditional lifestyle or traditional gender roles are strongly rooted within the Cypriot society. Their beliefs are not so consistent. One may argue that cultural conservatism and tradition influences their attitudes and beliefs more than those of their male contemporaries. The role models of these adolescents are mainly their parents and family thus, it is likely that they will adopt the family roles, which exist within their families. However, the findings indicate that they are also influenced by the changes in the wider Cypriot and other societies, which they observe or become aware through the mass media. Such influences lead of them to adopt more liberal attitudes.

Gender and Sexual Roles

Culturally traditional ideas such as 'male is the leader of the family and the sexual life' seemed to influence not only family roles but sexual roles as well. It is interesting that the vast majority of the male participants (71%) reported that 'the husband should always satisfy the sexual needs of his wife', whereas only 55% of the female respondents had the same belief. The percentage for female respondents in the similar statement that 'the wife should always satisfy the sexual needs of their husband' was much lower (48%), whilst 72% of the male respondents agreed with that. The variations in gender were found to be statistically significant in both statements. It can be argued, that some female participants want to have and give sexual satisfaction from/to men, somehow though many of them are not quite confident about their beliefs. As Cypriot society is becoming more multicultural, and more

Europeanized people are beginning to consider whether they should adopt new ideas, or slowly integrate these into their own value system.

Some students belong to the cultural safety or the culturally traditional group that on one hand want and/or accept liberalism, on the other they are resistant to it. This means that some adolescents want to and do adopt new ideas, attitudes and beliefs from Western and modern societies related to sexuality. Simultaneously though they want or are 'forced' by society to accept traditional ways of life. To follow the traditional lifestyle in small conservative societies such as Cyprus is probably an easy thing to do. The difficulty is for a young person to diversify or choose other than the traditional way of life, especially sexual life. However, they acknowledge the importance of knowledge for sexuality and want to acquire knowledge but they are somehow afraid to express their need for it. Two of the groups identified through cluster analysis were characterized as such (see section 8.6). Group one is considered to be a cultural safety group: On one hand adolescents accept modern ways of life such as premarital relations, whilst on the other hand they had difficulties in ignoring strong cultural beliefs such as 'contraception is a sin'. Group four is considered to be a cultural traditional group as religious and cultural values and beliefs are strongly held. Church and its preaching are valuable and honoured by the participants of this group. Thus, the ambiguity reported by the female participants is not entirely surprising.

Considering the Cypriot socio-cultural determinants such as gender, religion and tradition, as discussed throughout this study, it can be understood that men felt very strong about their sexual ability; and that part of the 'husbands' duties' is to always satisfy the sexual needs their wives. Men also felt very strong about their wives obligation to always satisfy their husbands' sexual needs. Although many females seemed to be more independent nowadays, some of them are still very conservative (more than males). In addition, many males probably do not actually see them as independent or acknowledge

that. In the study of Dandies et al. (2002) among Palestinian male and female university students, 54% of the respondents believe that the wife should respond to the husband's sexual desires. The association between independence and satisfaction of sexual need focuses on the idea that as females are becoming more independent, it is expected that they would not view satisfaction of their husbands as an obligation, but rather than as a mutual desire, will and satisfaction.

The findings of this study reveal that premarital relationships are more likely to be accepted for males than for females. More than half (64%) of the males and almost half (45%) of the females believe that 'it is acceptable for the man to have sexual relationships before marriage'. The participants were more conservative with women's premarital attitude. Forty-two percent (42%) of the males and 31% of the females believe that 'it is acceptable for the woman to have premarital sexual relationships'. Variations in gender were found to be statistically significant in both statements. It can be concluded that the Cypriot society still has different attitudes, beliefs and views of genders especially regarding sexuality. The previous decades of conservatism and traditionalism seemed to exist in contemporary Cyprus. Many taboos still exist, such as homosexuality and premarital sexual relationships for females. Despite that several years have passed from the Cyprus Youth Organization study (1997) overall the beliefs of young people regarding premarital sexual relations are more or less the same. In that study the majority (74.7%) of the young people reported their acceptance of male premarital relations, but fewer agreed with females having premarital relations (48.7%). Although the church preaches chastity for both genders, it seems to be almost totally ignored for males, whereas for females the case is not exactly the same. One wonders that since premarital sex is acceptable for most males, but is less acceptable for females, with whom are the males having sexual relationships? And do males view those women they have sex with in a different way than those women they marry? The most likely answer to the first question is that males,

including male adolescents, have casual sex with prostitutes and foreign tourists neither of whom are considered the kind of women one expects to marry. Premarital sex with Cypriot women normally takes place when the couple becomes engaged to be married, usually with the approval of their parents. There are some signs of change; in a recent study (Cyprus Youth Organization, 2002) about Cypriot youth 31% of the females and 44% of the males reported that males will marry a woman that they love even though she is not a virgin. It must be noted that those who were more reluctant to marry a woman that is not a virgin were the adolescents. It is apparent that young people view their gender and sexual roles differently, however both males and females do share similar attitudes and beliefs on this. Furthermore, it was somehow expected that respondents from urban areas were more likely to be more acceptant of females' premarital sexual relationships than respondents from rural areas. Arguably, more challenges, stimulations and/or sexual information exist in the cities compared to rural areas, thus people are more likely to be more open-minded. In Cypriot society often people from rural areas are more conservative, more concerned with 'honour' and what people say, and less acceptant to more liberal ideas and/or changes.

The different gender roles related to sexuality within Greek-Cypriot society are also depicted in the statement 'my parents would not approve if they knew I had sexual relationships', where female respondents (60%) were more likely to agree compared to the male respondents (44%). This confirms that is more likely for parents to accept premarital sexual relationships of their sons than their daughters. It seems that parents are more strict with adolescent girls than adolescent boys. However, within Greek-Cypriot culture contradictions and double standards exist: The Greek-Orthodox church is against premarital relations (even if one is engaged to be married); society seemed to be more acceptant with male premarital relations; and for engaged couples sexual relations are approved or even expected by parents.

Regarding contraception, most of the students reported that they do not accept that 'condom is the responsibility of the man only' (67%) nor that 'contraception, in general, is the responsibility of the woman' (47%). Thus, many of them believe that contraception is the responsibility of both genders. According to the Cyprus Youth Organization (2002), 79% of the young people believe that both genders should have equal responsibility for the use of any form of contraception. Furthermore, in the same study 30% believe that contraception is woman's responsibility, while 23% were undecided. Findings also showed that males were more likely to agree with both statements than females. It can be argued, that even though male adolescents seemed to feel responsible in knowing and using a condom, at the same time they feel that female adolescents are responsible for all other contraceptive methods.

Mitchel and Wellings (1998) found in their study, that adolescents felt uncomfortable discussing contraception at first sexual intercourse. Thus, adolescents need to have the knowledge, maturity and confidence to say what they want. Students in this study seemed to have some degree of self-confidence (about some things), but some do not.

Variations in urban and rural location were recorded. Those from urban areas were more likely to disagree that contraception is the woman's responsibility compared to those from rural areas. Once more findings reveal that there are differences in attitudes, beliefs and knowledge, as previously mentioned, among adolescents living in urban and those living in rural areas.

Cyprus laographia and/or literature underline the cultural differences between urban and rural areas such as gender and sexual roles, socio-economic status and lifestyle. Constandinou (1984) satirized females (mainly from urban areas) to hold the power and 'rule' Cyprus whilst men stay at home to do the housework. In this satire he illustrated how difficult for these reversal roles to actually happen. Moreover, in some songs or films (e.g. Vourate yitoni (the neighbours come running), Village stories) often people from the rural areas are presented as having lower educational status and be more conservative compared to the people from urban areas.

Sexual Relationships

Almost half (43%) of the respondents did not view children as the most important reason of a sexual relationship, whilst almost the other half (40%) did. It is assumed that pleasure and love plays an important role within young people's relationships. In one of the clusters (cluster 4) that was identified in this research marriage and childbearing was very much valued. This was considered as a cultural traditional group (see section 8.6).

The vast majority of all participants (80%) believe that 'marriage is the optimum level of a male-female relationship'. Similar results were found in the study done by the Research Associate International (RAI) consultants, about the Greek-Cypriot society that were presented by Mega channel on the 17/11/2002, stating that marriage is an important priority for most Cypriots. Home and family life is central to Christian Orthodox lifestyle. Marriage is regarded as the only appropriate and morally fitting place for sexual relations (Papadopoulos, 2002b), having children as the ultimate goal. Alternative ways of living are not much of an option such as staying single or cohabitating.

More than half (51%) of the participants do not believe that contraception is a sin, something which contravened the Christian Orthodox preaching whereas almost one third (32%) is still struggling with their belief, reporting as undecided. Further it was found that not even one third of those who reported that religion is very important to them believe that contraception is a sin. The only group who exhibited different beliefs was that of Famagusta respondents. They were more likely to believe that 'contraception is a sin'. This is compatible with the finding that they attend church more frequently, and that most of them reported that religion is important to them. However, the findings provide a curious contradiction, for if the Famagusta respondents followed the preaching of the church they would not engage in pre-marital sexual relationships. If this were the case the finding that 20% of these

students reported to be living with their mothers only (that may be unmarried, or divorced) compared with a much lower percent of respondents from other districts (5%-7%), this may indicate that their parents have less knowledge on sexuality issues and since they do not believe in using contraception, there is increase chance of unprotected sex and/or unwanted pregnancy.

Taking into consideration the female gender role in Cyprus, throughout history, in association with sexual relations, it is expected that females will probably be more emotionally connected within a relationship than a male. Historically and traditionally Cypriot women were viewed as good housewives, depending on men, expected to be virgins and have children after marriage. It can be argued that these cultural expectations and lifestyle create strong emotional bonds of females towards men; either due to the feelings of dependency or due to the lifestyle and way of living that was cultivated throughout the years. Therefore, it was not surprising that the vast majority of the girls (79%) believe that 'a sexual relationship with a person I do not love is not right', whereas only 58% of the male respondents had the same belief. Those who reported that religion is very important for them were more likely to agree with that statement.

In addition, homosexuality is generally not accepted by the Cypriot society, even though the Cypriot government, in line with other European governments, has recently decriminalised it amongst consenting adults. Moreover, the youth sub-culture with its ambivalent self and sexual identity, struggles to fit in with the wider culture which also finds itself in the unenviable position of having to achieve an equilibrium between two opposing forces, those of change and those of tradition. All these conditions are confusing for adolescents who, as their sexual urges, due to hormonal changes, reach their highest position and as they also struggle to define who they are, they need consistency, stability and support.

Homosexuality is a strong example that shows the impact of church and conservatism within everyday Cypriot life. Almost two thirds (65%) of the respondents believe that 'a sexual relationship with a person of the same sex is not right'. Consequently, most adolescents do not accept or tolerate homosexuality. Thus, it is difficult, in Cyprus, to be openly homosexual as it may put enormous strain on homosexuals and their families. This may lead to many negative social and health-related consequences (Papadopoulos, 2002b). Similar findings were recorded in the Cyprus Youth Organization study (2002), where 54% of the young people did not accept homosexual relationships. Moreover, in this study, males had stronger opinion (70%) than females (60%) in agreeing on this issue. This can probably be because male homosexuality is more commonly known about. It is possible that many people relate a homosexual with the loss of one's 'maleness'. Due to the new legislation, sometimes homosexuality may be superficially accepted by the Greek-Cypriot society but in reality is very much criticized. The reason is probably that most of the people do not want to be seen or associated with homosexuals from the fear of questioning their own sexuality by others. Cypriots pay attention to what other people say, as honour and family name are important assets of dignity within Greek-Cypriot society. A characteristic of collectivist societies (Triandis, 1994), such as Cyprus, is knowing about others. Although this has positive effects, it also means that individual privacy -when needed - is more difficult to achieve. The result of this is secrecy about issues that are considered of moral nature, for fear of unwanted consequences. Most of the respondents reported that it disturbs them to be with someone who has AIDS. Despite the knowledge for HIV/AIDS and the plethora of campaigns on this particular subject, many young people still feel uncomfortable being at school with infected people mainly due to fear of possible stigma or gossip when one 'hangs out' with an HIV/AIDS individual. They want to avoid being branded as 'homosexual' or even 'promiscuous'. Cypriot laographia underlines collectivism with the following motto: "It is better to loose an eye, rather than your good name and reputation". Fortunately, not

all young people adopt this belief. On the contrary, in the study conducted in Greece by Merakou et al. (2002) with high school students regarding HIV/AIDS attitudes and beliefs, only a very small percentage (4.75%) reported to reject their friend/schoolmates if they were infected. Although Greece and Cyprus have very similar cultures, it appears that the larger population of Greece and its membership of the E.U., which has resulted in population mobility, may have diluted its collectivistic characteristics.

Views on Education for Sexuality

The analysis of this research study recorded that despite the vast majority of the respondents (76%) stating that religion is important in their lives, they did not seemed to have a clear opinion about the role of church in sexuality education; however, its presence is not ignored. Twenty-nine percent (29%) of the students want the church to be involved in sexuality education. This was also identified in one of the cluster groups. Arguably, this can be attributed to an inner struggle between the ideology of Christianity and their needs within modern Cyprus. Participants from Paphos were more likely to disagree with the church involvement compared to the other districts. This is of special interest since Paphos is a district where church has a unique presence: It is the origin of Archbishop leaders of Cyprus (Makarios III and Chrysostomos) and the senior leader (apart from the Archbishop) of the Holy Synod is considered to be the Bishop (mitropolitis) of Paphos. An explanation of this finding can be that some people from the community of Paphos may consider it an honour that the Archbishop comes from their community, thus involvement with issues that are not primarily within Christian values and beliefs undermines the seriousness and importance of the Church of Cyprus. Some adolescents may be afraid or hesitate to express church involvements in sexuality education because of the values, ideas and beliefs that were cultivated with their families all these years.

In contrast to participants' beliefs on church involvement on sexuality education, they were definite (81%) about the need for school's active involvement in sexuality education. Students believe that the school has a significant role to play in educating for sexuality. According to a study by the Cyprus Youth organization (2002) the school was the first choice of young people for delivering sexuality education. It can be argued that this is probably because school creates some safety of knowledge (what and when to say, to what extent) and that students believe that the school can provide them with the correct information.

The vast majority of the participants (90%) reported that they prefer to have sexuality education in secondary school and not during their earlier years. Their view at what level they feel is appropriate to have sexuality education is very important to consider. On the other hand, in several countries sexuality education is included in primary education also; this may not be so urgent in Cyprus at this point. Cultural and societal taboos, conservativeness, hesitation and fear for sexuality education due to the belief that sexuality education will initiate or increase sexual activity are some of the reasons that one could argue to explain this response of the students. Cultural expectations may be another reason that reduces the importance of sexuality education. For example, in Cyprus much importance is given on achieving good grades and going to university. Thus, topics such as sexuality that do not contribute to this achievement often are not seen as necessary or important. This is understandable if one related the notion of culture to Bourdieu's 'habitus' (Bourdieu 1984 and 1977). As people live within a social environment (their habitat) they are influenced by it. It is not easy to deviate from one's habitus. It can be argued if one can do that. Nevertheless, challenging one's social environment and habitus, this may form a source of change.

By the age of fourteen one should have basic knowledge on sexuality, sexual and reproductive health, before one is faced with dilemmas and create the

possibility of engaging in risky behaviour. Participants' opinion and beliefs on the timing of initiation of sexuality education depends on the influence of their socio-cultural environment such as parents, media and school. The Ministry of Education and Culture seemed to have the same belief with the students', since the pilot study for the two proposed sexuality programmes, that was implemented in the academic year 2002-2003 was directed at third grade secondary school students. An evaluation of both programmes (medically-oriented and multi-thematic) was done indicating that the medically-orientated programme was more successful than the multi-thematic one. However, at this moment that this thesis is written there is no formal announcement about the evaluation.

In this study it was found that adolescents want their parents to also teach them about sexuality. This is associated with the students' belief of parents as being the ideal resource. The Netherlands' success in reducing the teenage birth rate is attributed to being a more open culture, allowing schools and parents to talk about sexuality issues with no embarrassment (Kiddy, 2002). However this successful tactic is not easy to be applied in Cyprus. The main difference is culture and its determinants. Cypriots do not have the infrastructure of discussing and exploring sexuality issues. This is something that is in its initial steps. Furthermore, most importantly due to conservatism (as mentioned above), changes are not easy to be made especially to such sensitive issue such as sexuality. Both, schools and parents, needs sexuality education and the development of self as to become more open-minded and acceptant to new trends and modern ways of life. As culture constantly changes, people need to adjust. Greek-Cypriot adolescents want their parents to have a significant role in the implementation of sexuality education. Except for the personal input of each parent within the family, cooperation with school authorities and other interested parties as well as educating themselves will create a more unified, harmonic environment for the

promotion of sexual health and the development of a healthy adolescent, either at home or school.

As previously mentioned (see chapter 5), in recent years, mass media in Cyprus is becoming more and more powerful. Mass media could play a role in promoting attitudes and in opening up the public debate on this sensitive issue. Forty-three percent (43%) of the participants reported that mass media influences their beliefs and behaviour. Currently in Cyprus, the mass media's role on promoting safer sex or in debating sexual health issues is almost non-existent. Mass media can be used in a constructive way in cooperation with other organizations in promoting sexuality health. In England, mass media campaigns form part of a four-part strategy to reduce teenage pregnancies (Kiddy, 2002).

However, mass media campaigning and the production of scientific programmes targeting adolescent sexuality have to be funded by someone. Whilst such funding should primarily be made available by the Cypriot government, as it is in most European countries, the stimulus and pressure for it should be coming from health promotion agencies. Given the relative scarecity of them in Cyprus, the school becomes an important agency for applying such pressure. In addition, those advising the government on health issues also have a role to play. However, in Cyprus both the schools and health agencies are employed by the government, which makes their role exceedingly difficult. The lack of independent voice, which could campaign and pressurize the government, is a barrier to any speedy progress in the involvement of the mass media in more obvious, positive and effective ways. This concept was described by Foucault in his discussions about power (see chapter 2). Culture is concerned with everything that is meaningful in connection to power relations (Foucault, 1980). Foucault goes further to also emphasize the importance of language and its use. For example, what and how media report something has a direct influence on people's ideas, beliefs and attitudes. Often mass media present tragic events such as the story of a girl who gave birth home alone (see chapter 5), without analyzing the socio-

cultural and the personal reasons which resulted in this unfortunate situation. Additionally, some mass media are controlled by political parties or the church. Therefore, they promote and project ideas within the ideology they support.

Development of self is an essential factor in promoting sexual health and preventing unwanted conditions. Almost one third (29%) of the respondents reported that 'it is difficult for me to say no, when someone asks me something that I am opposed to' and 15% did not even have an opinion on the matter, reporting as undecided. Therefore, more emphasis should be given through education regarding skills. Consequently, sexuality education should not be medically-oriented but it should promote the development of self and acquiring skills as to maximize the possibility of having good sexual health and understanding of sexuality. It can be argued that adolescents with low self-esteem and/or lack of assertiveness are more vulnerable in engaging in risky behaviours.

8.6 Group of Responses/Respondents

During the analysis of the data four groups or clusters were identified based on the responses of the participants as was discussed in the previous chapter. Although these groups do have similarities, some differences exist between them. This might not be the ideal grouping of respondents or responses, however it gives an indication of adolescents' attitudes and beliefs and the different adolescent groups that are formed within the contemporary Greek-Cypriot society regarding sexuality.

The **1st group** included 52% male participants, living in rural areas. The participants have less educated parents than the other groups and have reported limited communication with their parents regarding sexuality issues. The respondents within this group acknowledge the need for further sexuality

education, considering school and church as very important factors in delivering such education. It is interesting that despite their belief in church involvement in sexuality education (96%) most of them accept premarital relations (81%). However, an important 44% believe that contraception is a sin.

Overall, this is considered to be a ***cultural safety*** group. They want to know more about sexuality issues, however this as they reported can not be achieved without the strong presence of the church. It is somehow difficult for them to open themselves to accept and behave in a different way than culture 'permits'. It seems that culture remains of conservatism throughout the years have an impact on their daily living. Moreover, living in a rural area might be another reason influencing the responses of the participants, as it was found that there is some variation in urban and rural location regarding knowledge. As discussed previously in this chapter, several times students from rural areas were more traditional and/or conservative in their responses.

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The **2nd group** included in its majority (74%) female participants, living in urban areas. The participants within this cluster have limited communication with their parents about sexuality matters but have more communication with them compared to the other groups. Almost all of the participants in this group believe in premarital sexual relationships. May be this is an expressed need of suppressed feelings or due to rebelliousness towards a society in which gender roles are not so equal or elucidative yet. They believe that the purchase and use of condoms is the responsibility of the man and that contraception is the woman's responsibility at a much higher degree compared to the other groups. Although a liberal group it seems that they may not be so comfortable in purchasing condoms. Arguably, this may be attributed to the Cypriot collectivist culture.

Overall, this can be considered a ***liberal group*** of participants, a group that is influenced by contemporary changes and challenges. Nevertheless, one may argue that, it may be a high-risk group for sexual health, if they do not have

the necessary skills and knowledge to live within a contemporary European Cypriot society. The participants in this group reported having moderate knowledge on certain sexuality issues such as anatomy and physiology. However, they did report the need to know more about STI's and conception.

The **3rd group** included mainly male participants (61%), living in urban areas. Despite having overall more educated parents than the other groups, the level of communication between them was also limited. The participants within this group are aware of the need for sexuality education, as 42% (the highest percentage compared to other groups) of them reported that school has important role to play and should be involved in sexuality education.
Overall, this is an ***educational group*** that strongly believes in education for sexuality. It seems to be a more flexible and open to accept changes than the 1st group in sexuality matters. The participants' attitudes and beliefs are probably influenced from their immediate environment, which seemed to have higher level of education and it may be argued that is expected from them to value education (see chapter 7).

Fifty-six percent (56%) of the participants in the **4th group** were males, living in urban areas. The respondents within this group have the least communication (almost non-existent) with their parents compared to the other groups. Moreover, they reported to be deeply religious and traditional. This can be understood if their role models from the immediate environment believe in the traditional Cypriot family structure and way of life. They consider marriage and childbearing as highly important. They also deeply believe that contraception is a sin and that church should be involved in sexuality education. Participants of this group accept in a much lower degree of premarital relationships. They believe that condom is the responsibility of the man, whilst they do not believe that contraception is a woman's responsibility.

Overall, this group is a ***cultural traditional group***, as it is more close to religious and cultural values. There is a statistically significant difference between this group ($\overline{X}$ =0.27) and group one ($\overline{X}$ = 1.47; p< 0.05).

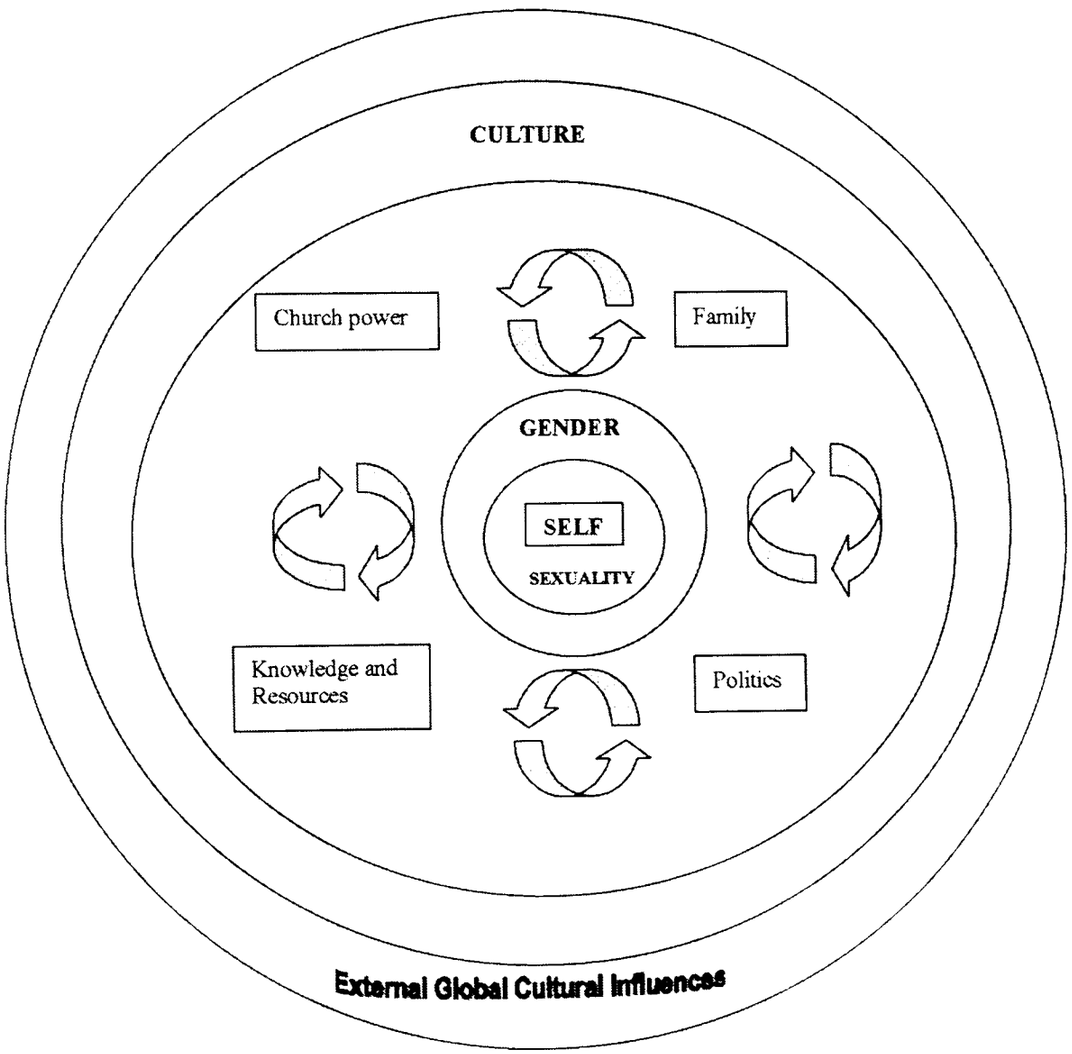
8.7 Developing a Theoretical Explanatory Model

Based on the findings of this study and on the literature review a theoretical explanatory model was developed as to provide an understanding of Greek-Cypriot adolescents' sexuality and sexual and reproductive health (Figure No.8.7.1).

Throughout this study the strong influence of culture was highlighted, local and global, in everyday life. More specifically what characterizes Cypriot culture in relation to sexuality issues are certain interconnected factors such as church, family knowledge, resources and politics. These are presented within a circle because they are interrelated and inter-dependant factors within Cypriot society. With the same logic all concepts such as gender and sexuality are presented within circles. The rounded arrows reinforce this inter-dependant relationship as they represent the interaction and influence of one concept with the other. In addition, a circle has no beginning nor ending, thus interactions may begin from anywhere. However, a circle does have a center and this is one's self.

The ethnohistory of Cyprus depicted the powerful role of the Greek Orthodox Church. Even in contemporary years the presence of the church within everyday life can not be ignored. For example, the church partially owns a television station; several church representatives are in key positions in different societal organizations/associations such as for those dealing with narcotics. The church's presence and involvement is valued and welcomed, however sometimes a step backward may be needed by the church as to

Figure No.8.7.1: Theoretical Explanatory Model of Sexuality



understand the contemporary young people's needs. In addition, the church has a lot of wealth and this increases its power. In all four student groups identified in the previous section the church or religious influences existed at a different degree in each group. Despite that, several times society and politicians do not exactly adopt the church's positions. A characteristic example is the decriminalization of homosexuality in 1998. As previously discussed, such actions may have been taken due to the pressure of European harmonization and not because most politicians really believed in them.

The church preaches the principles of Orthodoxy and anyone is free to adopt them. However, forgiveness, support and understanding are essential components of Orthodox Christianity and anyone, who that at some point of his/her life may have behaved outside those principles, can always be forgiven.

The contradictions and double standards regarding the issue of sexuality within Cypriot culture, as discussed previously in this chapter, creates confusion and ambivalence among adolescents. This may influence their beliefs, attitudes and personal decisions. However, how Cypriot adolescents interpret and understand concepts and meanings of sexuality issues and how they act depends on several factors such as their family environment, role models and their level of education on these issues.

Greek-Cypriot culture young students value family very much. Most of the participants want their parents to talk to them about sexuality matters, meaning that they trust them and that they value their advice. Nevertheless, all four groups identified in this study reveal that parent-child/adolescent communication on this matter is limited to non-existent. The education of parents on sexuality, personal taboos, the personality of both parents and child are some of the factors that can influence parent-child/adolescent communication. Once again honour and reputation is emphasized within

Cypriot culture. Therefore, family bonds are important. Even these days some people may fight or even kill to 'preserve' the honour of the family. Sometimes young people prefer not to communicate with their parents, because they assume their disapproval. More than half of the participants in this study reported that their parents would not approve if they knew they had sexual relations. Arguably, strong family bonds (without been invasive to adolescent personhood) and open communication may sometimes delay first sexual intercourse as well as reduce high-risk behaviour.

As seen through the literature politics are thought as essential in promoting health. Their role is important, since politics can reinforce or minimize a health promotion idea or a societal reformation. Politicians can develop, promote and vote for a policy or law that is associated with sexuality issues. At the time this thesis is written there is still a long discussion about the newly proposed marriage law. Several parliamentarians stated that same sex marriages are not allowed in Cyprus; therefore marriage of a transsexual (where there was a surgical change of sex and consequently gender) will be very difficult to be permitted under the new law (Michaelides, 2002). The inclusion of sexuality education in the Cyprus political agenda gave a new dynamic in discussing sexuality within the parameters of education and health.

In the past decade the Cyprus mass media has been dramatically increased and developed. As more than one third of the participants in this study reported that they are influenced by the Cyprus media their role within Cypriot society cannot be underestimated. During the past one-two years several discussions were presented by some media regarding sexuality matters mainly related to sexuality education. This (as mentioned above) was due to the fact that discussions about sexuality education were also taking place at a government level. However, very few programmes tried to have a scientific analysis on sexuality issues and even fewer have presented local research

evidence. It is the researcher's criticism that there is a different understanding of sexuality education, sexual and reproductive health and adolescents' needs and expectations among interested and involved parties such as politicians, parents and students.

Understanding one's own sexuality becomes more complicated when limited knowledge and almost no resources exist for young people to get answers for the plethora of their questions. The pilot study on the two proposed sexuality education programmes that took place during the academic year 2002-2003 is an excellent trial by the Ministry of Education and Culture. As mentioned previously, although it was found that students had some level of knowledge on STI's and HIV/AIDS, however they had little or no knowledge on other basic sexuality issues such as conception and contraception. Arguably, some topics may be given less emphasis compared to others. This may be also due to the lack of a holistic view of sexuality education.

Participants in this study reported wanting to have the opportunity to have a professional advice on whatever sexuality issue concerns them. In Cyprus, as discussed previously, limited resources exist for young people and especially for sexuality issues. The Cyprus Family Planning Association (that is a non-governmental organization) is the only organization that is particularly concerned with sexual and reproductive health and offers such services.

All these factors -church, politics, knowledge, resources, family- as they interact with the one another have a direct influence on gender roles within the Greek-Cypriot society. For example, more adolescent girls than boys reported that will get a parental disapproval if they had a sexual relation. Moreover, the issues discussed above have an impact on the individual; his/her self-image, self-identity and consequently his/her sexuality and health. Throughout this study the needs of young people that have been identified are directly related with the above issues. The participants feel the need for

exploring their knowledge and skills on sexuality issues; want deeply to feel comfortable within the families and talk to their parents regarding sexuality. They need their support. Young people also feel the need of services for youth that can easily use, visit or call whenever they have an inquiry or a problem. It is also important that the community acknowledges these needs and has a more active role. This is viewed with the interest of the government and the Ministry of Education and Culture as well as the parents association regarding sexuality education and its implementation. The pilot studies are an initial step in promoting sexual and reproductive health.

Going through this circle of understanding sexuality, the power of culture is highlighted as all findings from the literature and the study are part of culture. Apart from local culture, external global cultural forces influenced Greek-Cypriots. From ancient years until today, Cyprus continuously has had interaction with different cultures either as intruders, tourists or immigrants. It is wise to be selective at personal and national level on what to borrow and/or adopt from the different culture. It is expected that some diffusion of one culture with another will occur. However, the main focus is the self and its association as a human entity with its sexuality. Consequently, this includes the influence of socio-cultural factors such as gender, religion and politics. All these are part and formations of culture.

Summary

The discussion on the findings of this study, reveal that he concepts on which this research was constructed on (gender, education, religion, culture) seemed to be compatible with the general findings. The contribution of the explanatory model (Figure No.8.7.1) is that it offers an understanding of Greek-Cypriots adolescents' sexuality based on the impact of local and transnational socio-political norms and values on sexuality and sexual and reproductive health. This can be used as a guide by those interested in sexuality such as health educators, health professionals and schoolteachers.

It is an immediate need to support and guide adolescents to learn about themselves; and understand and become comfortable not only with their own sexuality but with other people's attitudes and beliefs that are related to sexuality and sexual behaviour.

This chapter discussed the results of this research study and it presented a theoretical explanatory model of sexuality. The needs of young people that were identified and suggestions on using of this model as well as general recommendations will be discussed in the following chapter.

CHAPTER 9

CONCLUSIONS

Introduction

As adolescents are the future adults, their health and general well-being, including their sexuality, sexual and reproductive health are important. This study was aiming to examine Greek-Cypriot adolescents' knowledge, attitudes and beliefs regarding sexuality and sexual health, exploring the influence of socio-cultural determinants. This chapter will present the conclusions of the present research study and provide several suggestions.

9.1 Conclusions

Throughout this study an extensive literature was presented based mainly on three concepts: Culture, gender and sexuality. From the review of the literature and the findings of this study several conclusions can be made:

1. Greek-Cypriot culture influences adolescents' sexuality.

Human sexuality can only be explained by understanding and addressing one's social organization and cultural meanings at different stages in his/hers historical development (Evans, in Morrissey, 1998). All the factors mentioned below such as gender, are part of culture and are interrelated. Therefore, their understanding, formation and development in relation to sexuality affects culture and culture is affected by it. The findings regarding the concepts/issues below lead to the overall conclusion that Cypriot culture has a strong impact on sexuality of young people.

2. Gender differences on sexuality exist within Cypriot culture.

Significant differences in gender were found throughout this research, such as on issues of male/female premarital sexual relations. Whereas it is acceptable for males to freely express their heterosexual sexuality and have sexual relations before marriage this is not considered appropriate for

females. Adding to this, it seems that parents have different expectations from and treatment for female adolescents than male adolescents, such as being more strict and non-acceptant if they knew that their daughter had a sexual relationship. Taboos still exist but are more apparent for females. Furthermore, participants feel that generally contraception is the female's responsibility, even though they consider condom as mainly a male responsibility. Different roles exist for males and females on sexuality matters. For example, most of the females feel that they should always satisfy their husbands, whilst males do not fell so strongly about this.

3. Greek-Orthodox church/religion is a strong influencing factor in understanding adolescents' sexuality.

Although almost all of the participants view themselves as religious, many of them do not exactly follow the preaching of the Orthodox Church. All of the four groups identified in the study are influenced at some degree by church/religion, whilst one of them feels strongly about church's involvement in sexuality education. This is not necessarily to be seen in a negative way but it highlights the impact of church within Greek-Cypriot society. Homosexuality is not acceptable by the church. In relation to this, the vast majority of the students believe that a sexual relation of two persons of the same sex is not right, thus homosexuality is an unacceptable form of sexual orientation. This may have an impact on adolescents as they search for their sexual identity. At the same time this finding reflects the conservativism of the Greek-Cypriot culture.

4. Family is very important within the context of Cypriot culture and society. Therefore, it influences adolescents' beliefs and attitudes regarding sexuality.

Family is a powerful influencing factor for young people; parents are the first role models. Despite this the study showed that very limited communication exists between parents and adolescents on sexuality issues. Many

adolescents are afraid of the rejection by and the criticism of their parents regarding their sexual beliefs or behaviour, therefore they avoid discussing relevant issues or asking for their help. Nevertheless, most of the adolescents reported that they want their parents to help and advise them on such issues and that for adolescents, their parents are the ideal resource on sexuality matters. This shows an inner desire to be more closed with their parents and also the importance they give to the family. Besides, literature confirms that honour and family name are essential assets in Cypriot society.

5. Greek-Cypriot students have some knowledge and awareness on sexuality matters.

Students are very knowledgeable in some health education matters, such as alcohol, however some are less knowledgeable in most of the sexuality matters such as conception and contraception. Moreover, their perceived need for knowledge is not compatible with their objective and self-perceived knowledge. For example, regarding conception and contraception, participants objective knowledge score was 41%, whilst 62% reported having some or no knowledge about these. However, only 13% reported the need to know more about these issues. It seems that they are not aware or do not want to report their real need. Somehow, they do not seem to be so eager to learn. Therefore, they do have a lack of knowledge in certain sexuality issues. Nevertheless, the Ministry of Education and Culture and the Ministry of Health seem to be aware of the need for sexuality education.

6. The need for more and better adolescent sexual health services.

Based on the findings Greek-Cypriot adolescents, although they considered health professionals one of the ideal resources for sexuality issues, usually they ask their friends for help instead of professionals or their parents or just they do not seek help. This may be because youth friendly services are almost non-existent in Cyprus and thus, only a small group of adolescents are able to seek professional advice when needed.

7. Sexuality education should begin in secondary school.

Almost all participants (90%) thought that sexuality education should start in secondary school. Nevertheless, it can be argued that this probably reflects the conservative attitudes that have been exhibited in this study as it shows that young people reflect the Cypriot society (this explanation was also given for conclusion number 3).

8. The urban/rural location and the district that one lives have some impact on adolescents' attitudes and beliefs related to sexuality.

Significant differences exist in knowledge of sexuality issues among students from urban and rural areas. It is important to highlight that as education for health is an essential human right, no one should have more or less advantage than others. Some variations also exist in attitudes and beliefs: Adolescents from rural areas are more likely to be more conservative compared to those from urban areas in certain cases such as in premarital relations.

Participants from the Famagusta district (that it is a rural area) have several variations compared to the participants from other districts regarding knowledge, attitudes and beliefs. However, as previously mentioned, these should be treated with caution due to the small number of participants from Famagusta.

9.2 Recommendations

As culture is the primary factor that influences one's attitudes and beliefs and consequently behaviour, its components such as gender need to be seriously considered in the promotion of health and understanding sexuality within Greek-Cypriot culture. Research has shown that effective interventions in altering attitudes and behaviour among adolescents are almost always gender-specific and culturally appropriate (Mabray and Labauve, 2002).

1. Even though pure knowledge is not enough on sexuality matters, its value can not be underestimated.

a) A multi-thematic approach involving educators and scientists from different backgrounds could be used in each school, forming a nucleus for promoting sexual health. It is the researcher's opinion that this team should not consist of a large number of people but rather a diversity of people. What is of primary importance in the selection of these educators, apart from their knowledge, is to feel comfortable, have the skills to approach sexuality in an open-minded manner and want to do this.

b) A common understanding (a baseline) of sexuality under a common educational policy will probably ease the implementation of a sexuality programme.

c) Evaluation of the existing health education programme and the two newly proposed programmes is essential, before any final sexuality programme is decided to be implemented in all Cypriot schools. The lack of knowledge or misinformation on basic sexual health issues such as conception, contraception, STI's may have detrimental consequences on adolescents' physical and mental health. Therefore, meticulous examination and serious attention must be given to these matters.

d) Socio-cultural factors (e.g. gender issues) need to be included and emphasized in such curriculum.

e) The teaching methodology should be reviewed. Experiential learning is considered more effective in discussing sensitive issues and cultivating critical thinking instead of the more traditional didactic methods.

f) More specialized books can be purchased for the school library for those who want to know more either students or teachers. Specialized organizations in sexuality issues, such as the Family Planning, can be a valuable resource for educators, parents and students.

g) School-teachers and health educators have a crucial role to play in the sphere of education for sexuality. They need to be trained and feel comfortable in delivering this to students.

h) Parents can be reached through a specially designed parental education programme. A similar programme runs in Cyprus regarding substance misuse based on a private and governmental cooperation. Arguably, if they talk to their parents probably they will be offered advice. Parents should be able to give a 'proper' advice and offer support when needed. Communication within the family regarding sensitive issues is better to be established from childhood and not to wait until the crucial stage of adolescence to be developed and explored. Although it is utopia to think that all parents will be educated or able to help their children, a strong argument is that the focus should be mainly on shaping young people's attitudes and beliefs as these are the future parents.

i) Differences in knowledge among urban and rural areas should be minimized.

2. Youth friendly services should be provided.

Based on the findings of the study there is a need for developing health services for adolescents. Health services should include services for adolescents. As options for young people to seek help for sexuality matters are poor, the government of Cyprus needs to be actively involved in this. Non-governmental organizations can also take the initiative for the development of such services. Young people need to be involved themselves as well as be in

decision-making positions as to successfully promote sexual and reproductive health.

These centres/services can advocate for youth's health, including sexuality, sexual and reproductive health, outside school within the community. Such services will be the backbone of the efforts of government and private, non-profit or voluntary organizations in promoting health. Primarily, the government must take serious action in developing a service aiming to meet the sexual health needs of adolescents. What is more appropriate for youth is to have confidentiality, privacy, accessibility, low cost and generally youth friendly environment services. In other words, these services should operate outside school hours and at times when young people can attend (e.g. lunch-times, Saturday mornings). They should also be situated at a convenient location, be informal and open to go with a friend (if one wants to) (Peckham, 1997). It will be important to have male and female staff in such services. According to Wilson et al. (1994), the Brook Advisory Centres (U.K.) is an interesting model for providing services for young people. A review of different centres can be useful in developing one in Cyprus. However, when applying such programmes in Cyprus, both societal and cultural differences should be taken into consideration.

3. Mass media should act as a support system.

Mass media must be used in a constructive way, such as press conferences, presenting open discussions based on local and international research. Television and radio programmes on cultural diversities, gender identities, beyond taboos and cultural conservatism will offer a broader view of what sexuality is or includes. Mass media might not be the ideal form of delivering academic and professional knowledge, it can however be a successful and massive way in passing on health messages to adolescents. It can also influence political decisions. Media power should be used though and not misused for the benefit of the public and not for personal ambitions of any reporter, quest or channel.

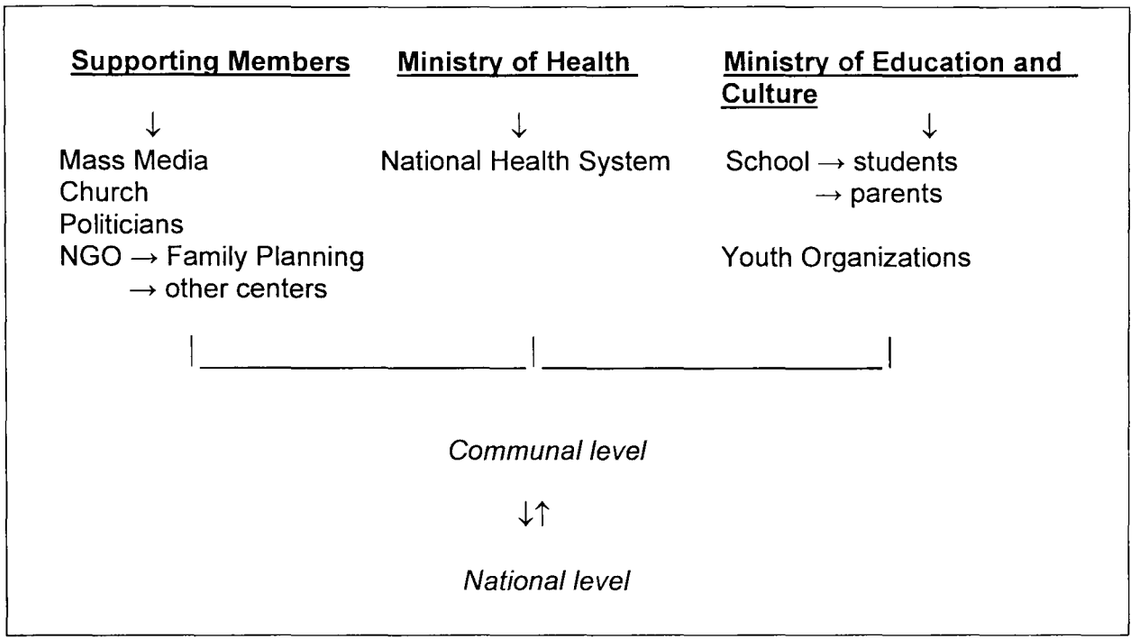
4. The link between the different interested groups such as FPA, government, ministries, experts and youth organizations should become more unified and strong.

Cooperation and collaboration among educators from different backgrounds and disciplines as well as societal positions, will provide a wider perspective in understanding, exploring and delivering education for sexuality in young people. For example, the development and/or reformation of policies and/or laws related to sexuality should be investigated and seriously promoted by politicians in collaboration with interested groups. Empowerment and support of any political act can come from experts, research and/or interested groups regarding sexuality matters.

The following table (Table No.9.2.1) presents the partnerships, cooperation and coordination of different resources such as services and organizations that can help towards the improvement of sexual and reproductive health. The Ministry of Health, through the National Health System, can cooperate with the Ministry of Education and Culture through schools, parents, youth organizations as well as with other interested and influencing groups such as the media and the Family Planning Association. Central coordination (at national level) and close cooperation of all the above mentioned parties can lead to the successful development and implementation of a national policy on sexual and reproductive health.

It is not enough for the relevant authorities/organizations to understand these needs they have to take action to meet them also. The framework of resources' partnerships on sexual and reproductive health, as presented here, can be a useful tool in achieving a multidimensional and national cooperation.

Table No.9.2.1: A Framework of Resources' Partnerships on Sexual and Reproductive Health



5. Professionals from many disciplines such as educators, doctors, nurses, sociologists and others, need to be encouraged to research Cypriot reality regarding sexuality or even more general health education/promotion.

Health and education authorities and employers should place sexuality high up on their agenda. Cyprus should create a data bank for health research and must investigate the hidden and untalked issues such as abortion, teenage pregnancy and homosexuality.

6. Variations in the district of Famagusta must not be ignored, but should be researched in more depth.

7. The use of the sexuality explanatory model (see chapter 8) can provide a baseline for any educator and health professional, organizational or group interested in promoting health in general and sexual and reproductive health in particular.

The idea behind this is to consider all factors that influence the formation and expression of sexuality, sexual and reproductive health, so as to prevent any unwanted conditions and promote health. All factors identified in this model, such as gender, family, religion and education, need to be understood within the context of the Cypriot culture. What is unique to Cyprus is the interrelationship between these factors and Cypriot culture. It is within this context that educating for health, preserving health, provision of health services and formation policies takes place.

This model is an initial step for further investigation of sexuality in Cyprus.

8. Further research

This study is an initial and seminal contribution to health and education, but more studies need to be undertaken in Cyprus. In future, the application of qualitative methodology can give a more in depth knowledge and understanding.

Research should extend to teachers/educators as to study their knowledge, attitudes and beliefs on sexuality issues. Identifying their strengths, weaknesses and needs it will undoubtedly ease the development of appropriate programmes in education and health.

As religious issues have been found as important influencing factors within Greek-Cypriot culture, further research is recommended focusing on the Orthodox religion and the role of the church within Cypriot society in relation to sexuality issues.

This diversity of research studies may give exact explanations and provide more evidence regarding the attitudes, beliefs and the needs not only of young people, but of the Greek-Cypriot society in general on sexuality

issues. These may alter or change some components of the sexuality explanatory model (see section 8.7). Nevertheless, this model provides a dynamic framework of understanding sexuality of Greek-Cypriot adolescents and at the same time it is stimulation for further research.

Epilogue

Sexuality is part of everyday life; is part of ourselves. Its understanding and expression affects one's health and well-being. When promoting health and educating for health, sexuality can not be excluded. The important thing is that Greek-Cypriot professionals in education and health should acquire the knowledge and skills so as to form attitudes and beliefs and promote health among adolescents and consequently the Greek-Cypriot society.

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APPENDICES

Appendix No.1: Perceptions on Adolescent Homosexuality of High School Health Teachers (Telljohan et al., 1995:19)

ITEM	Agree N (%)	Disagree N (%)
Perceived Health Risks		
Students are very degrading toward fellow students whom they discover are homosexual	108 (53)	6 (3)
Homosexual students are more likely than most student to feel isolated and rejected	122 (60)	13 (6)
Homosexual students are more likely than most students to abuse drugs	27 (13)	82 (40)
Homosexual students are more likely than most students to attempt suicide	61 (30)	32 (16)
Stereotypes		
Male homosexuals are more likely than most male students to be interested in the creative and performing arts	33 (16)	52 (26)
Female homosexual students are more likely than most female students to participate in athletics	25 (12)	76 (37)
Homosexuals experience a more intense sex drive than do heterosexuals	4 (2)	128 (64)
Homosexuals do not like members of the opposite sex	5 (3)	162 (81)
Homosexual adolescents who have the opportunity to experience a positive heterosexual relationship are likely to change their sexual orientation	11 (6)	105 (53)
Gay and lesbian rights are a threat to the American family and its values	69 (34)	79 (39)
The vast majority of homosexual students are satisfied with their sexual orientation	19 (10)	67 (34)
Homosexuality is becoming more prevalent in the adolescent population	30 (15)	47 (24)
School Issues		
Schools are not doing enough to help homosexual adolescents adjust to their school environment	72 (35)	43 (21)
The counseling staff in my school would be supportive of assisting gay or lesbian students	88 (43)	37 (18)
In your school, gay and lesbian support groups would be supported by your Administrator	14 (7)	110 (55)
Most teachers seem to exhibit significant prejudice toward homosexual students	26 (13)	59 (29)

Appendix No.2: IPPF Charter on Sexual and Reproductive Rights (IPPF, 1997:1-2)

The International Planned Parenthood Federation Charter on sexual and reproductive health rights was endorsed by the IPPF Members' assembly in 1995 and lays down fundamental principles that guide the work of the Federation. The Charter is intended to promote and protect sexual and reproductive rights and freedoms in all political, economic and cultural systems.

The 12 Rights in the Charter are:

1. **The Right to Life**, which means among other things that no woman's life should be put at risk by reason of pregnancy;
2. **The Right to Liberty and Security of the Person** which recognizes that all persons must be free to enjoy and control their sexual and reproductive lives and that no person should be subject to forced pregnancy, sterilization or abortion;
3. **The Right to Equality, and to be Free from all Forms of Discrimination** including in one's sexual and reproductive life;
4. **The Right to Privacy** meaning that all sexual and reproductive health care services should be confidential, and all women have the right to autonomous reproductive choices;
5. **The Right to Freedom of Thought** which included freedom from the restrictive interpretation of religious texts, beliefs, philosophies and customs as tools to curtail freedom of thought on sexual and reproductive health care and other issues;
6. **The Right to Information and Education**, as it relates to sexual and reproductive health to ensure the health and well-beings of persons and families;
7. **The Right to Choose Whether or Not to Marry and to Found and Plan a Family;**
8. **The Right to Decide Whether or When to Have Children;**
9. **The Right to Health Care and Health Protection** which includes the rights of health care clients to: information, access, choice, safety, privacy, confidentiality, dignity, comfort, continuity, and opinion;
10. **The Right to the Benefits of Scientific Progress** which includes the recognition that all clients of sexual and reproductive health services have the right of access to new reproductive technologies which are safe and acceptable;
11. **The Right to Freedom of Assembly and Political Participation** meaning among other things, that all persons have the right to seek influence governments to place a priority on sexual and reproductive health rights;
12. **The Right to be Free from Torture and Ill-treatment**, including the rights of children to be protected from sexual exploitation and abuse, and the right of all people to protection from rape, sexual assault, sexual abuse and sexual harassment.

Appendix No.3: Timetable

TIMETABLE

Literature Review	January 1998
Research Proposal	May 1998
Ethical and Access approval	May 1998 (initial) and November 2001 (reviewed)
Panel Meeting	July 1998
Preparation of the Questionnaire	September 1998 - January 1999
Pilot study (survey)	February 1999
Temporary suspension	*September 1999 - September 2001*
Literature review	September 2001 - January 2002
Communication with Headmasters	November 2001 - December 2001
Data Collection Main study (administration of the questionnaire)	December 2001 - January 2002
Data Analysis	February 2002 - October 2002
PhD transfer report and Panel	August 2002 - October 2002
Development of the theoretical framework	November 2002 - March 2003
Write up, binding and submission of thesis	April 2003 - September 2003

Appendix No.4: Permission for the study by the Ministry of Education and Culture

ΚΥΠΡΙΑΚΗ ΔΗΜΟΚΡΑΤΙΑ

Υ.Π.Π.21.1.03

ΥΠΟΥΡΓΕΙΟ ΠΑΙΔΕΙΑΣ ΚΑΙ ΠΟΛΙΤΙΣΜΟΥ
ΓΡΑΦΕΙΑ ΕΠΙΘΕΩΡΗΤΩΝ
ΜΕΣΗΣ ΕΚΠΑΙΔΕΥΣΗΣ
1434 ΛΕΥΚΩΣΙΑ

22 Νοεμβρίου 2001

Κυρία Χριστιάνα Κούτα
Λαέρτη 5
Άγιος Δομέτιος
2365 Λευκωσία

Θέμα: Άδεια για έρευνα στα Γυμνάσια σχετικά με τη σεξουαλική και αναπαραγωγική Υγεία.

Με τη παρούσα σας δίνεται η άδεια για έρευνα σε δημόσια σχολεία (Γυμνάσια) σχετικά με τη σεξουαλική και αναπαραγωγική Υγεία.

Έχει ληφθεί υπόψη ότι η έρευνα που θα γίνει θα βασιστεί στο υποβληθέν από μέρους σας ερωτηματολόγιο και έχει εγκριθεί από τους κυρίους Α. Κοιλανιώτη Π.Λ.Ε. και Α. Χρίστου Επιθεωρητή Φυσιογνωστικών.

Επίσης η άδεια δίνεται με την προϋπόθεση ότι τα αποτελέσματα της έρευνας δεν θα δημοσιευτούν χωρίς την εκ των προτέρων άδεια του Υπουργείου.

Αντρέας Σκοτεινός
Διευθυντής Μέσης Εκπαίδευσης

Appendix No.5a: Questionnaire (Greek Version)

MIDDLESEX UNIVERSITY

S.N.	C1	C2	C3	C4	CARD	C5
						1

ΕΡΩΤΗΜΑΤΟΛΟΓΙΟ ΓΙΑ ΤΗΝ ΚΑΤΑΝΟΗΣΗ ΤΩΝ ΑΝΑΓΚΩΝ ΤΩΝ ΕΛΛΗΝΟΚΥΠΡΙΩΝ ΕΦΗΒΩΝ ΣΧΕΤΙΚΑ ΜΕ ΤΗΝ ΣΕΞΟΥΑΛΙΚΗ ΚΑΙ ΑΝΑΠΑΡΑΓΩΓΙΚΗ ΥΓΕΙΑ

Το ερωτηματολόγιο αποτελείται από δύο μέρη. Το πρώτο μέρος περιλαμβάνει 13 ερωτήσεις και το δεύτερο μέρος περιλαμβάνει 38 ερωτήσεις. Θα χρειαστούν 20 περίπου λεπτά για να το συμπληρώσετε.

Το ερωτηματολόγιο είναι ανώνυμο. Θα τηρηθεί πλήρης εχεμύθεια για όλες τις απαντήσεις που θα δώσετε. Η συμμετοχή σας στην έρευνα αυτή είναι πολύ σημαντική.

Ευχαριστώ πολύ για την συνεργασία σας,

Χριστιάνα Κούτα

*The presentation of the questionnaire has been modified for the purposes of binding of this thesis.

ΜΕΡΟΣ ΠΡΩΤΟ

ΒΙΟΓΡΑΦΙΚΑ ΣΤΟΙΧΕΙΑ

Παρακαλώ όπως διαβάσεις προσεκτικά την κάθε ερώτηση. Απάντησέ την βάζοντας σε κύκλο τον αριθμό με τον οποίο συμφωνείς.

1. Φύλο

	c6
Αγόρι	1
Κορίτσι	2

2. Πόσο χρονών ήσουν στα τελευταία σου γενέθλια;

	c7
13	1
14	2
15	3
16	4

3. Με ποιους ζεις τώρα;

	c8
Μητέρα και πατέρα	1
Μόνο με τη μητέρα	2
Μόνο με το πατέρα	3
Μητέρα και πατριό	4
Πατέρα και μητριά	5
Με άλλους	6

4. Πόσα αδέλφια έχεις;

	c9
0	1
1	2
2	3
3	4
4	5
5	6
6+	7

5. Μήπως έμεινες καμιά φορά στάσιμος/η;

	c10
Όχι ποτέ	1
Ναι, μια φορά	2
Ναι, δύο ή περισσότερες φορές	3

6. Που ζεις τώρα;

	c11
Πόλη	1
Χωριό	2

7. Σε ποια επαρχία μένεις;

	C12
.....	

8. Ποιο είναι το επίπεδο εκπαίδευσης που έχει η μητέρα σου;

	c13
Δεν πήγε ποτέ σχολείο	1
Αποφοίτησε από το Δημοτικό	2
Αποφοίτησε από το Γυμνάσιο	3
Αποφοίτησε από το Λύκειο	4
Ανώτερη Σχολή	5
Πανεπιστήμιο	6
Δεν ξέρω	7

9. Ποιο είναι το επίπεδο εκπαίδευσης που έχει ο πατέρα σου;

	c14
Δεν πήγε ποτέ σχολείο	1
Αποφοίτησε από το Δημοτικό	2
Αποφοίτησε από το Γυμνάσιο	3
Αποφοίτησε από το Λύκειο	4
Ανώτερη Σχολή	5
Πανεπιστήμιο	6
Δεν ξέρω	7

10. Ποια είναι η θρησκεία σου;

	c15
Χριστιανός Ορθόδοξος	1
Μαρωνίτης	2
Χριστιανός Καθολικός	3
Χριστιανός Προτεστάντης	4
Μάρτυρας του Ιεχωβά	5
Άλλη (παρακαλώ αναφέρατε)	6

11. Πόσο σημαντική είναι η θρησκεία στη ζωή σου;

	c16
Πολύ σημαντική	1
Κάπως σημαντική	2
Καθόλου σημαντική	3

12. Πόσο συχνά πηγαίνεις στην εκκλησία;

	c17
1 φορά την εβδομάδα	1
1-2 φορές το μήνα	2
1-2 φορές το χρόνο	3
3-4 φορές το χρόνο	4
Καθόλου	5

13. Πόσο σημαντική είναι η θρησκεία στη οικογένεια σου;

	c18
Πολύ σημαντική	1
Κάπως σημαντική	2
Καθόλου σημαντική	3

ΜΕΡΟΣ ΔΕΥΤΕΡΟ

ΓΝΩΣΕΙΣ ΓΙΑ ΣΕΞΟΥΑΛΙΚΗ ΚΑΙ ΑΝΑΠΑΡΑΓΩΓΙΚΗ ΥΓΕΙΑ

Παρακαλώ βάλε σε κύκλο την απάντηση που θεωρείς σωστή.

1. Η γονιμοποίηση του ωαρίου γίνεται

	c19
στη μήτρα	1
στις σάλπιγγες	2
δεν γνωρίζω	3

2. Ο ιός του AIDS δεν μπορεί να μεταδοθεί με το αγκάλιασμα ή την χειραψία.

	c20
Σωστό	1
Λάθος	2
Δεν γνωρίζω	3

3. Ο ιός του AIDS μπορεί να μεταδοθεί με την σεξουαλική επαφή άνδρα - γυναίκας.

	c21
Σωστό	1
Λάθος	2
Δεν γνωρίζω	3

4. Ο ιός του AIDS δεν μεταδίδεται από κουνούπια.

	c22
Σωστό	1
Λάθος	2
Δεν γνωρίζω	3

5. Δεν μπορείς να καταλάβεις ένα άτομο από την εξωτερική του εμφάνιση, εάν έχει οποιοδήποτε σεξουαλικά μεταδοτικό νόσημα

	c23
Σωστό	1
Λάθος	2
Δεν γνωρίζω	3

6. Το αντισυλληπτικό χάπι δεν προστατεύει από σεξουαλικά μεταδοτικά νοσήματα (π.χ. Σύφιλη, HIV/AIDS).

	c24
Σωστό	1
Λάθος	2
Δεν γνωρίζω	3

7. Το ανδρικό προφυλακτικό είναι από τα ασφαλέστερα προφυλακτικά μέσα για τα σεξουαλικά μεταδιδόμενα νοσήματα.

	c25
Σωστό	1
Λάθος	2
Δεν γνωρίζω	3

8. Μια γυναίκα είναι πιθανόν να μείνει έγκυος κατά την πρώτη σεξουαλική επαφή.

	c26
Σωστό	1
Λάθος	2
Δεν γνωρίζω	3

9. Αν η γυναίκα κατά την διάρκεια της περιόδου της έχει σεξουαλική επαφή, υπάρχει πιθανότητα να μείνει έγκυος.

	c27
Σωστό	1
Λάθος	2
Δεν γνωρίζω	3

10. Η όλη συμπεριφορά του ατόμου μπορεί να επηρεαστεί εάν καταναλώσει 3 λίτρα (pints) μπίρα.

	c28
Σωστό	1
Λάθος	2
Δεν γνωρίζω	3

11. Η χρήση ναρκωτικών ουσιών δεν προκαλεί κανένα απολύτως πρόβλημα στην υγεία του ατόμου.

	c29
Προκαλεί	1
Δεν προκαλεί	2
Δεν γνωρίζω	3

ΠΗΓΕΣ ΚΑΙ ΑΝΑΓΚΕΣ

Παρακαλώ βάλε σε κύκλο μία μόνο απάντηση.

12. Όταν έχω απορία / πρόβλημα σχετικά με θέματα σεξουαλικότητας συνήθως αποτείνομαι σε / ενημερώνομαι από

	c30
Φίλους	1
Γονείς	2
Αδελφό /ή	3
Καθηγητή /τρια	4
Γιατρό, νοσοκόμα /ο, ειδικό	5
Εκκλησία / ιερωμένο	6
Κανένα	7
Μέσα Μαζικής ενημέρωσης (τηλεόραση, ραδιόφωνο, εφημερίδα)	8
Οργανισμό / κλινική	9
Άλλους (παρακαλώ αναφέρατε)	0

13. Για μένα ιδανικότερο είναι να παίρνω ορθές πληροφορίες για θέματα σεξουαλικότητας από

	c31
Φίλους	1
Γονείς	2
Αδελφό /ή	3
Καθηγητή /τρια	4
Γιατρό, νοσοκόμα /ο, ειδικό	5
Εκκλησία / ιερωμένο	6
Κανένα	7
Μέσα Μαζικής ενημέρωσης (τηλεόραση, ραδιόφωνο, εφημερίδα)	8
Οργανισμό / κλινική	9
Άλλους (παρακαλώ αναφέρατε)	0

14. Σε βιβλία του σχολείου μου υπάρχουν πληροφορίες σχετικά με θέματα σεξουαλικότητας (π.χ. σύλληψη, αντισύλληψη, περίοδος, σεξουαλικά αισθήματα κ.λ.π.)

	c32
Ναι	1
Όχι	2
Δεν γνωρίζω	3

15. Εάν ΝΑΙ, μελέτησες κάποιο από αυτά ποτέ;

	c33
Ναι, μια φορά	1
Ναι πολλές φορές	2
Όχι ποτέ	3

16. Σε ποιο βαθμό γνωρίζεις τα παρακάτω θέματα:

		πάρα πολύ	πολύ	μέτρια	λίγο	καθόλου
Ανατομία και Φυσιολογία του γεννητικού συστήματος	c34	1	2	3	4	5
Σύλληψη	c35	1	2	3	4	5
Μέθοδοι Αντισύλληψης	c36	1	2	3	4	5
Σεξουαλικά Μεταδοτικά Νοσήματα (π.χ. Σύφιλη, HIV/AIDS)	c37	1	2	3	4	5
Βασικές αρχές για εποικοδομητική επικοινωνία	c38	1	2	3	4	5
Αλκοόλ, Ναρκωτικά	c39	1	2	3	4	5
Κάπνισμα	c40	1	2	3	4	5

17. Βάλε σε κύκλο ένα από τα παρακάτω θέματα που θα ήθελες περισσότερες πληροφορίες.

	c41
Ανατομία και Φυσιολογία του γεννητικού συστήματος	1
Σύλληψη	2
Μέθοδοι Αντισύλληψης	3
Σεξουαλικά Μεταδοτικά Νοσήματα (π.χ. Σύφιλη, HIV/AIDS)	4
Βασικές αρχές για εποικοδομητική επικοινωνία	5
Αλκοόλ, Ναρκωτικά	6
Κάπνισμα	7
Κανένα	8
Άλλο (παρακαλώ αναφέρατε)	9

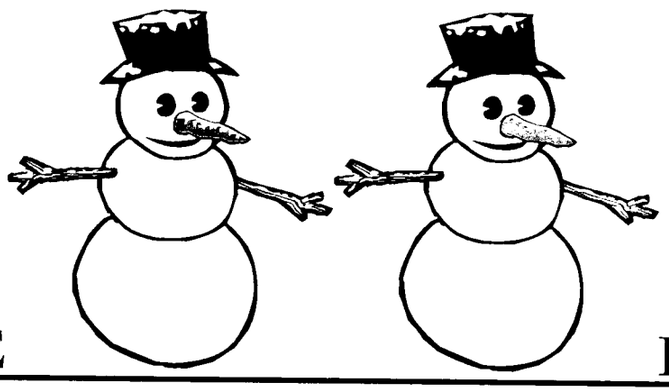
ΣΤΑΣΕΙΣ ΚΑΙ ΠΙΣΤΕΥΩ

Παρακαλώ βάλε σε κύκλο την απάντηση που θεωρείς ορθή.

		Συμφωνώ απόλυτα	Συμφωνώ	δεν έχω αποφασίσει	Διαφωνώ	Διαφωνώ απόλυτα
18. Η χρήση προφυλακτικού είναι θέμα που αφορά τον άνδρα μόνο.	c42	5	4	3	2	1
19. Η αντισύλληψη, γενικά, είναι ευθύνη της γυναίκας.	c43	5	4	3	2	1
20. Η εκκλησία πρέπει να έχει ανάμειξη στο θέμα της σεξουαλικής αγωγής.	c44	5	4	3	2	1
21. Το σχολείο πρέπει να έχει ενεργό ρόλο στη σεξουαλική διαπαιδαγώγηση.	c45	5	4	3	2	1
22. Ο σύζυγος πρέπει πάντοτε να ικανοποιεί τις σεξουαλικές επιθυμίες της συζύγου του.	c46	5	4	3	2	1
23. Αυτά που βλέπω / ακούω στην τηλεόραση / ραδιόφωνο / εφημερίδα επηρεάζουν τα πιστεύω και την όλη συμπεριφορά μου.	C47	5	4	3	2	1

		Συμφωνώ απόλυτα	Συμφωνώ	δεν έχω αποφασίσει	Διαφωνώ	Διαφωνώ απόλυτα
24. Μια σεξουαλική σχέση δύο ατόμων του ίδιου φύλου δεν είναι ορθή.	c48	5	4	3	2	1
25. Είναι αποδεκτό για τον άνδρα να έχει σεξουαλικές σχέσεις πριν από τον γάμο.	c49	5	4	3	2	1
26. Η σύζυγος πρέπει πάντοτε να ικανοποιεί τις σεξουαλικές επιθυμίες του συζύγου της.	c50	5	4	3	2	1
27. Η σεξουαλική διαπαιδαγώγηση πρέπει να αρχίζει από το Νηπιαγωγείο	c51	5	4	3	2	1
το Δημοτικό	c52	5	4	3	2	1
το Γυμνάσιο	c53	5	4	3	2	1
28. Είναι αποδεκτό για την γυναίκα να έχει σεξουαλικές σχέσεις πριν από τον γάμο.	c54	5	4	3	2	1
29. Με ενοχλεί να συναναστρέφομαι με άτομο που έχει AIDS.	c55	5	4	3	2	1
30. Η αντισύλληψη είναι αμαρτία.	c56	5	4	3	2	1

		Συμφωνώ απόλυτα	Συμφωνώ	δεν έχω αποφασίσει	Διαφωνώ	Διαφωνώ απόλυτα
31. Μια σεξουαλική σχέση με άτομο το οποίο δεν αγαπώ δεν είναι ορθή.	c57	5	4	3	2	1
32. Ο σημαντικότερος σκοπός σε μια σεξουαλική σχέση είναι η απόκτηση παιδιών.	c58	5	4	3	2	1
33. Πιστεύω ότι οι γονείς πρέπει να διδάσκουν τα παιδιά τους για τη σεξουαλικότητα και τις σχέσεις με το άλλο φύλο.	c59	5	4	3	2	1
34. Το σημαντικότερο ρόλο στην οικογένεια τον έχει η γυναίκα.	c60	5	4	3	2	1
35. Το σημαντικότερο ρόλο στην οικογένεια τον έχει ο άντρας.	c61	5	4	3	2	1
36. Οι γονείς μου δεν θα ενέκριναν εάν μάθαιναν ότι έχω σεξουαλικές σχέσεις.	c62	5	4	3	2	1
37. Συνήθως δυσκολεύομαι να λέω όχι όταν μου ζητούν κάτι ενάντια στη θέληση μου.	c63	5	4	3	2	1
38. Ο γάμος είναι το αποκορύφωμα μιας σχέσης άνδρα - γυναίκας.	c64	5	4	3	2	1



ΚΑΛΕΣ ΓΙΟΡΤΕΣ

Appendix No.5b: Questionnaire (English Version)

MIDDLESEX UNIVERSITY

S.N.	C1	C2	C3	C4	CARD	C5
						1

QUESTIONNAIRE FOR THE UNDERSTANDING OF THE NEEDS OF GREEK-CYPRIOTS ADOLESCENTS IN RELATION TO SEXUAL AND REPRODUCTIVE HEALTH

This questionnaire consists of two parts. The first part includes 13 questions and the second part includes 38 questions. You will need approximately 20 minutes to complete it.

The questionnaire will be anonymous. All the information you provide will be treated within the strictest of confidence. Your contribution to this research is very important.

Thank you very much for your cooperation,

Christiana Kouta

*The presentation of the questionnaire has been modified for the purposes of binding of this thesis.

PART ONE

DEMOGRAPHIC DATA

Please answer each question carefully. Put in a circle the number you agree with.

1. Gender

	c6
Male	1
Female	2

2. Your age one your last birthday

	c7
13	1
14	2
15	3
16	4

3. Whom you are living with now?

	c8
Mother and father	1
Only with mother	2
Only with father	3
Mother and stepfather	4
Father and stepmother	5
With others	6

4. How many brothers/sisters do you have?

	c9
0	1
1	2
2	3
3	4
4	5
5	6
6+	7

5. Have you ever had to repeat the same grade?

	c10
No never	1
Yes, once	2
Yes, twice or more	3

6. Where are you living now?

	c11
City	1
Village	2

7. Which district are you living in?

	C12
.....	

8. What is the educational level of your mother?

	c13
Never went to school	1
Graduated from elementary	2
Graduate from Gymnaesium	3
Graduate from Lyceum	4
Tertiary school	5
University	6
Do not know	7

9. What is the educational level of your father?

	c14
Never went to school	1
Graduated from elementary	2
Graduated from Gymnasium	3
Graduated from Lyceum	4
Tertiary school	5
University	6
Do not know	7

10. What is your religion?

	c15
Christian Orthodox	1
Maronite	2
Christian Catholic	3
Christian Protestant	4
Jehovah's Witness	5
Other (Please state)	6

11. How important is religion in your life?

	c16
Very important	1
Somehow important	2
Not important	3

12. How often do you go to church?

	c17
Once a week	1
1-2 times a month	2
1-2 times a year	3
3-4 times a year	4
Never	5

13. How important is religion in your family?

	c18
Very important	1
Somehow important	2
Not important	3

PART TWO

KNOWLEDGE ON SEXUAL AND REPRODUCTIVE HEALTH

Please put in a circle the answer you consider correct.

1. The fertilization of the ovum takes place in the

	c19
Uterus	1
Fallopian tubes	2
Do not know	3

2. HIV/ AIDS can not be transmitted by hugging or shaking hands.

	c20
Right	1
Wrong	2
Do not know	3

3. The HIV/ AIDS can be transmitted with male-female sexual contact.

	c21
Right	1
Wrong	2
Do not know	3

4. The HIV/AIDS virus is not transmitted by mosquitoes.

	c22
Right	1
Wrong	2
Do not know	3

5. You can not understand a person from his appearance if he/she has a sexually transmitted disease.

	c23
Right	1
Wrong	2
Do not know	3

6. The contraceptive pill does not protect you from a sexually transmitted disease (e.g. Syphilis, HIV/AIDS).

	c24
Right	1
Wrong	2
Do not know	3

7. The male condom is one of the safest preventative measures against sexually transmitted diseases.

	c25
Right	1
Wrong	2
Do not Know	3

8. It is possible for a woman to become pregnant during the first sexual intercourse.

	c26
Right	1
Wrong	2
Do not know	3

9. There is a chance for a woman to become pregnant if she has sexual intercourse during her menstrual period.

	c27
Right	1
Wrong	2
Do not know	3

10. Three pints of beer may alternate a person's behaviour.

	c28
Right	1
Wrong	2
Do not know	3

11. The use of narcotic drugs have no effect on someone's health.

	c29
Yes there is	1
No there is not	2
Do not know	3

NEEDS AND RESOURCES

Please put in a circle only one answer.

12. When I do have a question/ problem related to sexuality issues I usually get the information from

	c30
Friends	1
Parents	2
Brother / Sister	3
Teacher	4
Doctor, Nurse, Specialist	5
Priest	6
No one	7
Mass Media	8
Organization, Clinic	9
Other (please state)	0

13. The best way of getting correct information for sexuality issues, for me is from

	c31
Friends	1
Parents	2
Brother / Sister	3
Teacher	4
Doctor, Nurse, Specialist	5
Priest	6
No one	7
Mass Media	8
Organization, Clinic	9
Other (please state)	0

14.In my school there are books related to sexuality issues (e.g. conception, contraception, period, sexual feelings...)

	c32
Yes	1
No	2
Do not know	3

15. If YES, have you ever read any of these?

	c33
Yes, once	1
Yes, many times	2
Never	3

16. To what extent do you know the following subjects:

		very much	much	moderate	some	none
Anatomy and physiology of the reproductive system	c34	1	2	3	4	5
Conception	c35	1	2	3	4	5
Methods of Contraception	c36	1	2	3	4	5
Sexually Transmitted Diseases (e.g. Syphilis, HIV/AIDS)	c37	1	2	3	4	5
Basic principles on constructive communication	c38	1	2	3	4	5
Alcohol, narcotics	c39	1	2	3	4	5
Smoking	c40	1	2	3	4	5

17. Put in circle <u>one</u> of the following subject that you feel you need more information on.

	c41
Anatomy and Physiology of the reproductive system	1
Conception	2
Methods of Contraception	3
Sexually Transmitted Diseases (e.g. Syphilis, HIV/AIDS)	4
Basic principles on constructive communication	5
Alcohol, narcotics	6
Smoking	7
None	8
Other (please state)	9

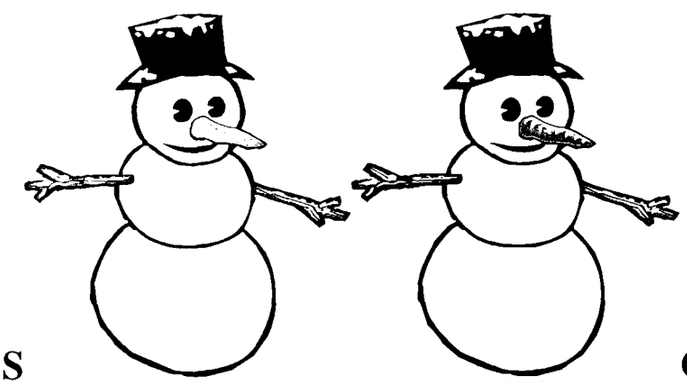
ATTITUDES AND BELIEFS

Please put in a circle the answer you consider correct.

		Completely Agree	Agree	Undecided	Disagree	Completely Disagree
18. The use of a condom is the responsibility of the man only.	c42	5	4	3	2	1
19. Contraception, in general, is the responsibility of the woman.	c43	5	4	3	2	1
20. The church should be involved in matters of sexuality education.	c44	5	4	3	2	1
21. The school should have an active role in sexuality education.	c45	5	4	3	2	1
22. The husband should always satisfy the sexual needs / desires of his wife.	c46	5	4	3	2	1
23. What I see/hear on radio, television, newspaper influences my beliefs and generally my behaviour.	c47	5	4	3	2	1
24. A sexual relation between two persons of the same sex is wrong.	c48	5	4	3	2	1
25. It is acceptable for a man to have sexual relations before marriage.	c49	5	4	3	2	1
26. The wife should always satisfy the sexual needs / desires of her husband.	c50	5	4	3	2	1

		Completely Agree	Agree	Undecided	Disagree	Completely Disagree
27.Sexuality education should begin in pre-primary school	c51	5	4	3	2	1
in primary school	c52	5	4	3	2	1
in high school	c53	5	4	3	2	1
28. It is acceptable for a woman to have sexual relations before marriage.	c54	5	4	3	2	1
29. It disturbs me to be with someone who has AIDS.	c55	5	4	3	2	1
30. Contraception is a sin.	c56	5	4	3	2	1
31. A sexual relationship with a person I do not love is not right.	c57	5	4	3	2	1
32. The most important reason for a sexual relationship is to have children.	c58	5	4	3	2	1
33. I believe that parents should teach their children about sexuality and relationships with the other sex.	c59	5	4	3	2	1
34. The most important role in a family is that of the woman.	c60	5	4	3	2	1
35. The most important role in a family is that of the man	c61	5	4	3	2	1
36. My parents would not approve if they knew I had sexual relationships.	c62	5	4	3	2	1

		Completely Agree	Agree	Undecided	Disagree	Completely Disagree
37. Usually it is difficult for me to say no, when someone asks me something that I am opposed to.	c63	5	4	3	2	1
38. Marriage is the ultimate goal of a relationship between a man and a woman.	c64	5	4	3	2	1



SEASON'S GREETINGS

Appendix No.6: Reminder Letter to the Headmasters

Christiana Kouta
Address
Tel.

To ----------
District (e.g. Nicosia)

December 4th, 2001

Subject: Research on Sexual and Reproductive Health

Dear Mr/Ms ----------,

Following our telephone conversation on the ---/11/2001 for the above matter, I would like to remind you that I will be in your Gymanaesium for the distribution of my questionnaire in a 3rd grade class on the **---/12/2001 at ----- (time)**.

Please, do contact me if any change occurs in your programme.
Thank you for your cooperation

Regards,

Christiana Kouta
Educational Officer

Appendix No.7: Information Paper

Title: Sexuality, sexual and reproductive health: an exploration of the knowledge, attitudes and beliefs of Greek-Cypriot adolescents

Aim of the study

The aim of this study is examine Greek Cypriot adolescents' knowledge, attitudes and beliefs about sexuality, and sexual and reproductive health and to explore the influence of the dynamic interplay of transnational and local socio-cultural norms and values.

Aims and Objectives

- To identify the cultural factors which influence sexuality, and sexual and reproductive health attitudes and beliefs of Greek Cypriot adolescents
- To describe the knowledge, attitudes and beliefs of Greek Cypriot adolescents about sexuality, and sexual and reproductive health
- To assess Greek Cypriot adolescents' awareness of the existing resources related to sexuality issues
- To develop explanatory frameworks based on the impact of local and transnational socio-political and cultural norms and values on sexuality and sexual and reproductive health

The project

This project is undertaken as part of Doctoral Studies (PhD) at the Middlesex University in London. The results will be used by the Cyprus Family Planning Association and the Ministry of Education and Culture and could be used by the Ministry of Health.
This is a Pan-Cyprian study and schools have been randomly selected to participate in it. The researcher aims to distribute questionnaires to approximately 568 3rd grade high school students in the selected public schools.

If you need further information about the study you are very welcome to contact me.

Christiana Kouta
Address

Appendix No.8: Questionnaire Field Note

KOUTA CHRISTIANA

Questionnaire Field Note

Response Rate

- Serial Number

  . Valid
  . Non-valid=
  . Total = Keep=
  . Boys= Girls=

- City
- School
- Class
- No. of students in class Boys= Girls=
- No. of all students in 3rd grade class in school
- Teacher and Title
- Headmaster
- Date and Time
- Have you ever had any sexuality education before?
- Have you ever had anatomy and physiology of the reproductive systems in your Anthropology/ Biology class?
- Any problems
- Students' Questions/ Inquiries

Appendix No.9: Thank-you Letter

Christiana Kouta
Address
Tel.

To ----------
District (e.g. Nicosia)

January 29th, 2001

Subject: Research on Sexual and Reproductive Health

Dear Mr/Ms ----------,

I would like to thank you for your cooperation in the distribution and collection of my questionnaire, with the above theme, for research purposes.
Please, do express my appreciation to Mr/Ms ---------- for their promptness during the research process.

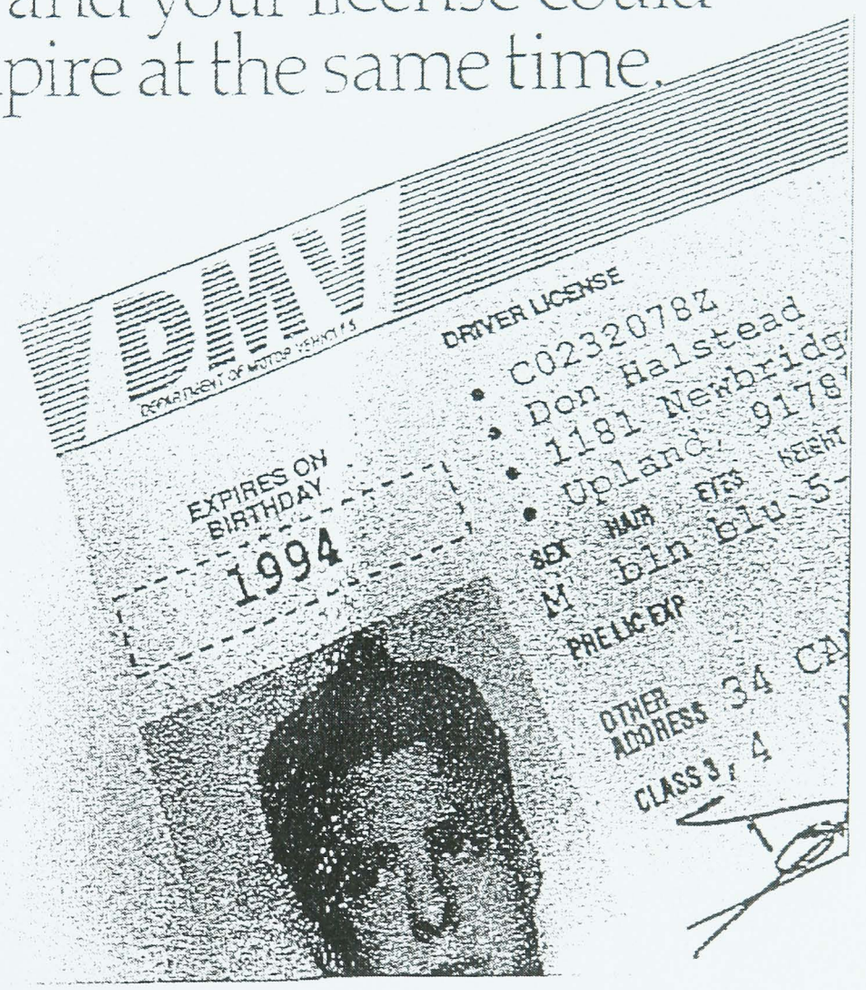
The results of this study will be given to the Ministry of Education and Culture. An information letter will be sent to you informing you about the results of the study.

Regards,

Christiana Kouta
Educational Officer

Appendix No.10: America Responds to AIDS- poster for HIV/AIDS

If you get the AIDS virus now, you and your license could expire at the same time.



Let's say you don't think you'll get AIDS because you don't know anyone who has it. There's one thing you're overlooking.

AIDS is caused by a virus called HIV. And HIV doesn't lead to AIDS right away.

Someone can have HIV for many years without even knowing it. This means that many people in their twenties who have AIDS may have been infected with the virus while they were in their teens.

Don't wait for proof that AIDS exists. It does. So, take precautions now.

If you'd like more information about the AIDS virus, how to prevent it, and how to reduce risks, call the National AIDS hotline, 1-800-342-AIDS. The hotline for the hearing impaired is 1-800-AIDS-TTY.

AMERICA RESPONDS TO AIDS.